MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 13, 2001
10:00 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
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FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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AGENDA PAGE

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P R O C E E D I N G S

MR. HACKBARTH: I'd like to welcome our guests. Please have a seat as quickly as possible since we're going to go ahead and start.

The first item on our agenda this morning is quality improvement for health plans and providers. This is a mandated study that we've discussed several times now. The purpose of our discussion today is to vote on our final recommendations. Mary, Karen?

DR. MAZANEC:

Thank you. Today we will focus on the revised draft recommendations and report for the quality improvement standards in the Medicare program. At this meeting we are asking the commissioners to comment on the content of the revised report and to come to closure on the recommendations.

I will begin by briefly recapping our analysis and findings and then Karen will discuss the recommendations.

As you recall, in the BBRA, Congress directed MedPAC to look at how Medicare should apply quality improvement standards to the fee-for-service in the Medicare+Choice programs. At the October meeting, we presented our analytical approach and findings and I just want to briefly summarize that right now.

As you recall, our analysis consisted of three parts. First, we identified the goals of quality improvement standards and then examined the manner in which they are applied by private accreditors, regulators, and purchasers. Next, we analyzed the M+C standards and the QI efforts in the fee-for-service program. And finally, we evaluated the feasibility of applying standards comparable to the M+C standards to each type of plan and provider.

Based on our analysis, we had four major findings which are summarized on this slide. First, we concluded that providers and plans have varying capacities to comply with quality improvement standards. At present, only HMOs

can fully meet all of the M+C requirements. Second, oversight and private and public purchaser efforts are often duplicative. We see this duplication in both the application of process and structure standards and in the development of measures. Deeming status may actually ease this problem. Third, rewarding or assisting providers or plans may further stimulate quality improvement. And finally, more research is needed, especially on measures and the most effective ways to stimulate quality improvement.

At the last two meetings in October and November, we heard a lot of different things from the commissioners. From their discussion, we identified four broad considerations that guided us in writing the draft recommendations. These considerations are listed on this slide.

First of all, beneficiaries should receive high quality care, whether they choose the fee-for-service or the M+C program. Quality improvement efforts are imperative and

Medicare should lead these quality improvement efforts. Finally, all plans and providers should work to improve quality in accordance with their capabilities.

Now Karen will talk about the draft recommendations.

MS. MILGATE: As Mary said, Congress asked us to advise them on how to apply quality improvement standards. The three draft recommendations in front of you include guidance specifically on how to apply standards, but also suggest that quality improvement standards should be applied in a broader context that includes other strategies to stimulate quality improvement.

Today we will be presenting three draft recommendations, but this slide really sums up the principles that we heard in the discussions at the last two meetings that underline all of these recommendations and we wanted to put them out explicitly before talking about the recommendations themselves.

First, that Medicare should take into account the differing capabilities of plans and providers when applying standards and apply standards flexibly to account for those.

Second, that Medicare should reward exemplary performance and quality improvement whether as a result of voluntary efforts or mandatory requirements.

Third, that Medicare should seek to reduce oversight duplication when developing and applying standards and coordinate and build on private sector oversight efforts.

Fourth, that recognizing there are gaps in the ability for different providers and plans to actually measure and improve care, that Medicare should assist providers and plans in performing quality improvement.

And finally, that recognizing that gaps occur in the knowledge about how to actually do quality improvement, that one role for Medicare is to, along with others such as ARC, research quality improvement measures and strategies.

These are the principles that we felt where there was general agreement within the Commission. The area where there seemed to be discussion was on what the appropriate level of quality improvement standards should be. So that's the primary discussion we would hope to have today.

So what we decided to do in presenting the recommendations is actually present recommendations two and three first, since those are the ones where there seem to be more general agreement, and then save the description of the discussion of recommendation one for last.

Draft recommendation two states that the Secretary should reduce duplication between public and private oversight efforts when applying quality improvement standards and measures. The report discusses several strategies for reducing duplications, however the two primary ones are in Medicare+Choice to make broader use of deemed status. Because the predominant form of Medicare+Choice plan at this time are HMOs, and many HMOs

are already accredited in the private sector, this could help lessen their burden and potentially reduce the unevenness between the playing field between HMOs and non-HMOs.

In the fee-for-service program, because deemed status is much more developed, the issue is more a matter of standardization of measures. Many different private and public sector purchasers are considering, and in some cases already requiring institutional providers to report on core measure sets. And so this recommendation suggests that Medicare should participate in coordinating those efforts and to try to make sure that the measures they use are as close as possible to any private sector measures.

Draft recommendation three combines two of the principles I spoke about earlier. The first is that the Secretary should assist plans and providers to improve quality. The second is that he should also encourage and fund research on appropriate measures and effective

mechanisms to improve quality.

The first part addresses the gap I spoke about earlier and the ability for providers and plans to improve quality and suggest that Medicare should help close this gap by providing technical assistance in such areas as collection and analysis of data, advice on effective mechanisms, and also potentially dissemination of best practices among providers and plans.

The second part recognizes the gaps in knowledge about effective mechanisms in measures and some of the report text talks about studying measures in areas where less is known about how to measure quality, looking at incentives, both that we might suggest at the plan or institutional provider level but also within, to work with physicians. And one of the other major barriers where it seemed there needed to be more research is in looking at appropriate risk adjustment methodologies to make it easier to publicly report information on individual providers.

This slide and the next one are both draft recommendation one. Between the discussion at the last meeting and responses to e-mails in between, staff have identified basically two options with which various commissioners agreed. We don't have actually option 1B or 1C here. When we put the options next to each other, we realized that, in fact, there were two concepts where there was general agreement between those options. And then a couple of others that could add in or not add in, depending upon how the Commission would discuss at this meeting.

So the first slide here are the two concepts within draft recommendation one which we felt were generally agreed upon. And then the second one is identifying areas of potential disagreement.

The first one in which we thought there was general agreement was that the Secretary should recognize differing plan and provider capabilities when developing and applying quality improvement standards and rewarding

exemplary performance.

Just to address quickly, Alan, your point on this, it probably is implied in the concept of applying quality improvement standards that you would take into consideration those different capacities when rewarding exemplary performance. We actually added in those words, which ends up looking kind of redundant, just to be more explicit. So that's something we'd be glad to have some discussion on. It seemed like that was potentially your issue with that concept.

And this, just to go over it again, recognizes that collecting and analyzing data and influencing quality is done different in different organizations. For example, PPOs have less ability to abstract information from medical records. Small institutions may have less ability than large institutions. And data may be more valid on one type of provider or plan than another.

The second concept with which we felt there was

general agreement was that the Secretary should reward plans and providers for exemplary quality improvement performance. At the last meeting, staff actually presented this as a separate recommendation but we heard from the Commission that, in fact, you felt that that needed to be a central piece of the strategy for applying standards and the rationale that we heard was that it was seen as a way to reward those who may, in fact, have more vigorous standards applied to them and perhaps lessen the distinctions between, for example, HMOs and non-HMOs.

And it was also seen as a more appropriate strategy for stimulating quality improvement than perhaps applying additional standards.

The last two concepts address the level of standards to be applied. On these two we felt like we heard a differing of opinion at the last meeting and wanted to highlight the two options and suggest what we heard in terms of arguments for and against. So I'll present some pros and

cons to these.

The first concept is that the Secretary should eliminate the requirement for HMOs to demonstrate quality improvement on the two QAPI projects. Those who thought this concept should be included suggest that this was one way to create a more level playing field between HMOs and non-HMOs in the Medicare+Choice program, and that it was inappropriate to have differing levels of standards in that program.

Those who didn't think it should be included, or that it was necessary to include it, suggested that it was appropriate to apply different standards, that in fact HMOs do do more and have more capacity to manage care. And simply because PPOs aren't able doesn't mean that you should take the standards off the HMOs. And further suggested that perhaps you could rely on rewards and some of the lessening of burden through deemed status to reduce that unlevel playing field.

Just a note, this one and the other one can be achieved through regulation. So let's be clear on that. there's no need to change statute for either of these to be included.

The second concept with which we felt there was some discussion necessary was that the secretary should apply quality improvement requirements comparable to those in Medicare+Choice programs to institutional providers in the fee-for-service program. Those who felt this should be included suggested this will create a more level playing field between fee-for-service and Medicare+Choice and if indeed many of these activities are already occurring it would not be a significant undertaking for CMS to require this level of standard or for providers to actually meet those standards.

Those who didn't think it was necessary to include it but suggest that these activities are already ongoing, that it wasn't necessary to require them if they're

happening on a voluntary basis and unless there was some suggestion that there wasn't enough quality improvement going on in the fee-for-service program. Once again, it might be possible to rely on the concept of rewarding high performers and a lessening of the duplication to reduce the unlevel playing field, so to speak, between Medicare+Choice and fee-for-service.

That is the presentation. We, of course, would appreciate comments generally, but specifically in this area. And we would also note that the draft that you have of the report was revised to include some of the other, more general comments that we heard at the last meeting. Specifically, we added a section on the cost impact of quality as well as the evolution of the science of quality improvement.

MR. HACKBARTH: Help me manage the time effectively here. What Mary and Karen have presented is their belief that we've got broad areas of agreement and a

couple of specific areas where there may be some disagreement. To be specific, they heard consensus on recommendations two, three and the first page of one. Did they hear correctly? If so, what I would like to do is initially focus on the areas of disagreement so we can make sure that we discuss those thoroughly and not waste our time on nuances.

DR. NEWHOUSE: Just one issue with the second bullet under one, which is --

MR. HACKBARTH: So the first page of one?

DR. NEWHOUSE: Yes, the reward plans and providers for exemplary quality improvement performance. There was a principle on an earlier slide that had reward high performance. And this only talks about improvement. So the question is if I've got a plan where already 95 percent of the AMI patients are getting beta blockers, does it not get a reward?

MS. MILGATE: The three concepts that I would

throw out as important in looking at what you would reward would be one, the one you just mentioned, where you have a high standard, like 80 percent get beta blockers. And you're at 90, so that's a standard that somebody set.

Another concept would be if you start down at a low level, say you're at 50 percent, the standard that is set is at 80, that if you actually get it up to 75 that's a pretty significant jump.

And then the third, that would recognize innovation and make sure that people aren't just going for the low-hanging fruit, is perhaps to reward innovative projects. So those are three different concepts that could probably be captured under the words high, if you prefer that word.

MR. HACKBARTH: Why not, Karen, just reward high performance?

MS. MILGATE: I think that's fine. I think all three of those could be captured under the words high

performance.

MR. HACKBARTH: I'd like to just stay with this issue for a second. The question that is on the table that Joe has raised is rewarding only high performance versus maybe high performance plus improvement plus innovation.

DR. NEWHOUSE: It rewards only improvement as it's currently worded.

MR. SMITH: Joe, I think what you say logically makes sense, but what troubles me here, thinking about beneficiaries, beneficiaries in low performing institutions and plans that do a lot of improvement are a lot better off than beneficiaries already receiving exemplary care.

If what we're trying to think about here is how do we use incentives and rewards in order to make high quality care more available to more beneficiaries, throwing more resources at institutions and plans that are already performing well doesn't accomplish that.

I understand the distinction that you draw, but

I'm not sure what the consequences of it are.

DR. STOWERS: I'm not trying to be redundant but I think it's important to have both of those in here. We've got to obviously reward those that do quality improvement, but there's lots of rewards other than just financial for those that have already accomplished the high level of performance. That could be decreased regulatory burden or whatever.

So I think it's important to get the message across here, that the rewards should be for both of those. So I agree with Joe entirely.

DR. BRAUN: I agree with Joe too, because actually I don't think beneficiaries are better off or as well off if there is a plan that's going 50 to 75 than they are with one that's already at 95, because they are obviously getting better care.

MR. HACKBARTH: So you're saying that you would reward both improvement and high performance?

DR. BRAUN: Yes.

DR. NEWHOUSE: If it's just improvement, I don't know what happens if I go from 50 to 75 and then back to 50 and come then back up to 75. Do I collect money every other year or what? I don't know how to handle that.

DR. REISCHAUER: I was going to make a related point which is, you can't get improvement payments year after year without getting the high quality, presumably. So there has to be some rather complicated reward formula here. But it should have penalties, as well.

MR. HACKBARTH: Can we just do a straw vote here? The proposal on the table from the staff was to reward a mixture of high performance, improvement, and innovation, as I understood it.

Let's just do a straw vote. How many favor that approach?

DR. REISCHAUER: Can I ask for a clarification? What do we mean by innovation if it doesn't result in high

performance?

MS. MILGATE: What it's designed to do is make sure that plans and providers don't just go after what they know how to do really well, and they don't look at things that they don't necessarily know how to improve on, but they do the work to understand what the measures could be, to develop those measures, and perhaps do some interventions where they learn what doesn't work. So that would push the science of quality improvement, so to speak.

Now you could perhaps suggest that is more of a research function and not have it on the table, but it comes up often in other settings where people talk about how to do this just to make sure that folks aren't just continuing to measure mammography, for example, simply because they know how.

MS. RAPHAEL: I'm not sure what's meant by innovation but I think an example might be if someone tackles doing something across sites or across providers,

rather than just in your particular domain. I think we should try to encourage efforts like that in the fee-for-service system because the handoffs are generally problematic areas. I don't know if that would fall under the innovation arena or not, but I think that might.

MR. SMITH: I think it's very hard to link in the same payment construct innovation and quality improvement. It seemed to me that the innovation issues were addressed in draft recommendation three and that if we want to elaborate on that, that's where we should do it. More resources ought to go into innovation but some innovative attempts may not produce very much, but we want to encourage that experimentation and testing.

But I don't think we want to link it to improvement outcomes.

MR. HACKBARTH: I'd like to press ahead here. The bottom line, from my perspective, is this is a case where I think we would really benefit from having a consensus

recommendation with everybody supporting it. So what I'd like to do is use a series of straw votes to sort of understand where people stand on this issue.

How many favor an approach that would say that we want to reward both high performance and improvement? A show of hands?

DR. ROWE: I'm trying to understand, as opposed to what?

MR. HACKBARTH: As opposed to high performance only.

DR. REISCHAUER: No, quality improvement.

[Simultaneous discussion.]

MR. HACKBARTH: Just a second. Don't confuse me. The options I see are high performance and improvement. That was one option that seemed to have just now a whole lot of support, if not unanimous support.

A second option is performance only, just high levels of quality only. I've not heard anybody argue in

favor of improvement only as yet.

DR. NELSON: But that's what the recommendation is.

MR. HACKBARTH: Oh, good point.

MS. MILGATE: The recommendation was intended to do both, but if it's not clear, we can change it.

MR. HACKBARTH: So let's do them all.

Performance and improvement, was there anybody who didn't support that? We may be able to cut to the bottom line here. Is that what the majority or unanimously we want?

MR. SMITH: Glenn, I think both in the spirit of consensus and because I think it makes sense, that doing both is the right answer here. I am worried that we create a situation where rewards, assuming scarce resources for rewards, rewards flow to low-hanging fruit rather than to improvement and that you're right, a beneficiary is better off at 90 percent than 75 but they're a hell of a lot better

off if you went from 50 to 75 than from 87 to 90. And beneficiaries don't often have choices that allow them to always end up in a 90-performing plan.

So I guess I'd be comfortable with both but with some text that made it clear that what we're after here is improvement. That we want to have everybody be high rather than...

MR. HACKBARTH: It looks to me like we've got unanimous agreement on that formulation. So let's move on.

So any other issues now about draft recommendation two and three? Or the first part of one. Again, I want to focus for a second on the areas where Karen and Mary heard a lot of agreement in our previous discussion.

MS. BURKE: Following up on Joe's point and David's point, I think the question of innovation, whether there's a way to modify three to reflect this sort of broader concept, I think makes good sense. That we ought to be rewarding people for doing things that look at things

differently. So if there's a way to say that in three, to make it clear, I think it's a good idea.

MR. HACKBARTH: Any other...

DR. REISCHAUER: Why don't we just say effective and innovative mechanisms to improve quality?

DR. LOOP: Is there any merit in putting recommendation two before one and three, so that you reduce the duplication first?

MS. MILGATE: We actually proposed it that way at the last meeting and the discussion we heard was that because the central question Congress had asked us to comment on was the application of standards, that we really should put the central answer first, even though duplication does have to do with the application of the standards. That seemed to be the reason we put one first.

MR. HACKBARTH: I think that still makes sense. That is the principal question before us.

I have a question for my education about draft

recommendation two. As I read the statute, the Secretary currently has the authority to deem a private organization for HMOs and say that if you're accredited by X you've effectively met these statutory requirements. Am I reading it correctly?

MS. MILGATE: Yes, statute does say that. It hasn't been carried out yet.

MR. HACKBARTH: Where does that process stand?

MS. MILGATE: Actually, currently CMS is evaluating various private accreditor standards that have applied for deemed status for Medicare+Choice. So the discussion in the report is we think that needs to go forward and CMS should do its best efforts to make sure it is possible to deem. And then there's other discussion on broad use of deeming, rather than -- there was some concern on the part of some plans that CMS might, in fact, pick and choose standards rather than saying you've met all the standards if you meet accreditor standards that only one

here or one over here.

So there's also some discussion in the report on how it should be broad use of deeming. So that's essentially what the recommendation does, is say get on with it, let's do it and make it a broad use.

MR. HACKBARTH: Okay. Anything else on draft recommendation two, three or the first part of one?

So what I take from that is that people are prepared to support those pieces as written with the amendments we've already discussed?

MS. MILGATE: I'm sorry, Glenn, can I just make sure that we decide on Alan's point?

MR. HACKBARTH: Which point, Karen?

MS. MILGATE: I think Alan suggested that talking about applying -- this was in the first part of recommendation one -- that recognizing the different plan and provider capabilities when you're rewarding high performance was redundant with the second sentence? Or

should I not bring that up again?

DR. NELSON: I think you're going to be doing some rewriting based on this discussion. Also, the redundance may not stand out as much if the second part, some portions of the second part is plugged into the middle of it. So don't worry about it right now.

MS. MILGATE: So just work with your comments.

DR. NELSON: Yes.

MS. MILGATE: Fine. Thank you.

MR. HACKBARTH: So let's move to the second page of draft recommendation number one. Let's just take the two bullets in turn.

Eliminate requirement for HMOs to demonstrate quality improvement. Here again, I have a question just for my edification. As I read the statute, there is no statutory requirement that HMOs demonstrate quality improvement. This is a requirement imposed by the Secretary, not by the Congress; is that correct?

MS. MILGATE: Yes. The statutory provision that it's linked to says, when you identify your aids for improvement, that the plan shall take action to improve. It's been my reading that what CMS did was say the way they wanted to determine compliance is to suggest you show you demonstrate improvement. One could suggest that there are other ways to determine that some entity has taken action to improve.

So yes, we believe there's regulatory flexibility for them to do that.

MS. NEWPORT: I think part of the challenge after BBA was enacted was that it was a required improvement year after year. Even though you might be at 98 percent, moving it to 100 percent or 10 percent improvement every year was an impossible standard to meet. So I want to make sure folks understand that improvement beyond a certain point in a certain area may not necessarily be achievable.

DR. NEWHOUSE: I wasn't sure from reading this

exactly what we meant, but as I thought about it, what I thought we should have was that the plan would have an internally generated and approved quality improvement plan, but it would not have necessarily specific quantitative targets like the 10 percent target, and that CMS would not specify targets that applied uniformly to all HMOs. So it would be much more a bottoms up kind of activity.

I also thought we should add some language somewhere, possibly in the text, that said this did not imply anything about quality assurance activities, that we assume quality assurance remained in place.

DR. WAKEFIELD: Could you just clarify this discussion for me? Regrettably, I was out for most of the last meeting, and so I missed the discussion that might have fed into this particular bullet.

My general sense is that in an ideal world, I think that what we're trying to do is harmonize requirements to the extent possible, rather than doing anything -- unless

it makes sense -- that is a step backwards or away from trying to move the field forward in terms of quality improvement, from the institutional level, to the plan level, to the clinician level, et cetera, as tools are available to help accomplish that.

So when I see this written this starkly, it makes me really kind of uncomfortable but maybe there's something I'm missing here that supports this. Could you just give me a little background?

MS. MILGATE: The background I think is that there was the discussion, I would say, was trying to balance what you just put forth which is harmonizing the requirements that are out there and trying to move forward with quality improvement, recognizing what we do and don't know. But there was also concern that there was differences in what's applied to different entities and that perhaps it was inappropriate to have such a difference exists and would create disadvantages for some plans and essentially penalize

them potentially for being good at quality improvement.

So to me that was the balance that the Commission was trying to struggle with at the last meeting. One of the suggestions was to add this in to address that unlevel playing field. But others did feel, as you may feel, that it wasn't necessarily appropriate to take that requirement off.

MR. SMITH: Like Mary, I missed -- I missed the whole November meeting, so I may be a little bit behind in the discussion. But I share her discomfort with the argument implicit in the first bullet.

Leveling the playing field is a different idea than getting the highest quality that we can get. It seems to me that, given the recognized differences in capacity language in the earlier recommendations, that having done that it doesn't seem to me, on behalf of a sort of abstract level playing field principle, we ought to say therefore we want to level down.

I think that's what the first bullet implies. I'm very uncomfortable with that, rather than the suggestion that we have different circumstances where different things are possible. And in every case, the standard ought to be as high as those circumstances allow.

I think combined with recommendation -- I guess it's now three, the second bullet does a better job of that. We may want to play with the language.

DR. BRAUN: I'm very uncomfortable with that, at least the way that it's worded, because I certainly don't think we want to eliminate a requirement to demonstrate quality improvement. Maybe it could be done through a different means than presently, but we certainly don't want that.

In fact, I think it goes against our consideration or our principles as the draft says that all plans and providers should be working to improve quality in accordance with their capabilities. Somehow, to eliminate that seems

to be just the opposite.

MR. HACKBARTH: Let's do a straw vote on this. How many would like to see this language removed? In other words, strike the eliminate the requirement for HMOs.

Joe, you said you had a modification to offer?

DR. NEWHOUSE: Yes, I'd like the requirement to be a requirement for an approved internally generated QI plan rather than a CMS-generated, uniformly applied QI plan. I mean, I think the issue is how best to get to high quality and I think this tries to address Janet's concern about getting from 98 to 100 isn't really appropriate.

DR. ROWE: I think the other -- I mean, I associate myself with Janet's concerns with respect to the diminishing opportunity for quality improvement in those plans that have done a particularly good job.

Maybe we could get there by putting a word in here that says something like to demonstrate appropriate quality improvement, or something so that it gives somebody a hedge

so that if you're at 98 percent on something you're not getting dinged because you didn't increase by 10 percent the next year.

Maybe doing it Joe's way also does it but the problem is it falls out of the recommendation and is lost in the text.

MR. HACKBARTH: The message I took away from our last discussion was that many commissioners had reservations about any language in a recommendation that would look like a retreat.

DR. ROWE: Right.

MR. HACKBARTH: I understand that and in fact agree with that point of view.

The second bullet on this page, the second bullet on draft recommendation one, is actually an expansion as I see it. We are saying we need to press forward with quality improvement and do it for the institutional fee-for-service providers as well as for managed care plans.

What if we had a recommendation that said that. Then in the text said it doesn't look to us like there ought to be a quality improvement requirement only for HMOs? I don't see any reason why we couldn't say if it's good for HMOs then each hospital has to have two quality improvement projects. I don't see the reason for singling out HMOs.

We could take it out of the bold recommendation so there's nothing trumpeting retreat in the recommendation and just have a discussion of this issue in the text and have the recommendation language being press forward and expand quality improvement, not narrow it. How do people feel about that?

Murray, I know you have some thoughts about that. Feel free to express them.

DR. ROSS: I guess my one concern would be, if you're sending an action line to the Secretary or the Congress, you should be clear what that action line is. And if it's going to be in the text, that's more discussion and

amplification. So I guess I'm disagreeing slightly with that.

MR. SMITH: Jack, if we didn't try to modify bullet one, simply got rid of it, but then rewrote the second bullet so it said apply appropriate quality improvement requirements to both M+C providers and institutional providers in the fee-for-service program, I think that's both what Glenn and I were trying to get. I think it's --

DR. ROWE: I'm just allergic to the concept of eliminating anything that has to do with quality. So that's why I can't got there. I'm with you completely, Dave.

MS. MILGATE: Could I just clarify one point with Joe and Jack just to understand? Currently, CMS has retracted the 10 percent requirement for demonstrating improvement. But they still do require some improvement to be shown.

It seemed like what I heard you saying, Joe, is

they should generate some of their own targets on improvement. It sort of is where CMS is. So I don't know if we could discuss that and highlight that that's a good policy. Or does it go beyond that?

DR. NEWHOUSE: I'm obviously comfortable with that, but I think it applies even more forcefully if we go into the institutional providers because what's appropriate to improvement quality at a 50-bed hospital in Devil's Lake and what's appropriate at Mass General may be totally different.

MS. MILGATE: So generalize that statement.

DR. ROWE: I think there is an Alice-in-Wonderland aspect to the conversation, in part because we wouldn't want the American public to think that MedPAC is so out of touch with reality that we think everybody is at 99 percent, and therefore we want to make sure that they're not held to an impossible standard. I think very few people if any, with the possible exception of PacifiCare, are at 99 percent of

the ideal quality.

MS. NEWPORT: That's true. Thank you, Jack, for acknowledging that.

DR. ROWE: So we should recognize this is a high-class problem, if we have it, but I'm afraid we don't. I guess what we want to do is have some balance in the text or some statement about balance between the level of quality and its improvement and a recognition of the differences and capabilities of the different institutions.

Those are the two themes that I keep hearing. One is what level are you at versus how much are you changing? The other is what kind of an institution are you? Clearly, that has to be highlighted in some way.

MR. HACKBARTH: So, Jack, could you couch your point of view in terms of a recommendation? How would you like this second page to read?

DR. ROWE: Let's go back for a second and make sure we saw what was on the first page. We have the

different plan and provider capabilities taken care of, right? And we're rewarding plans and providers for exemplary quality improvement performance, right?

MR. HACKBARTH: Right.

DR. ROWE: So I think David answered the question adequately from my point of view in his recommendation, with respect to just getting rid of bullet one on this page and saying applying appropriate, or something like that. I think that does it.

DR. NEWHOUSE: Jack, would you have CMS generate the appropriate standards? Or would you have the institution generate the appropriate standards subject to CMS approval? Because the current standard it's kind of, as I understand it, one from the plan and one from CMS. And the one from CMS goes across all plans.

DR. ROWE: I don't have an opinion on that. I'm not sure. What do you think, Janet.

MS. NEWPORT: I think we set principles here.

This group shouldn't go to that micro a level on this one, Joe. I would suggest if we've got some broad principles then there's licensure requirements and standards you have to meet to be a contractor and the deeming. There's lots of things there.

I'm all for eliminating the word eliminate. So I'm aligning myself with David and Jack on that. But I think there's sets of standards out there that are much broader than we've had time to even think about.

DR. NEWHOUSE: That's one reason I said I thought we should put in some language about keeping quality assurance standards.

MS. NEWPORT: Don't we have that in the other piece.

DR. NEWHOUSE: So there's no confusion about we're trying to maintain some standards.

MS. NEWPORT: But I thought that was accomplished on the first page.

MR. HACKBARTH: So what I hear is a developing consensus to take out the first bullet, not have in the recommendation eliminate, have at least in the text discussion about there being appropriate standards or expectations of both HMO and fee-for-service institutional providers.

I'm less clear on whether people would like to see the language of bullet two change. It seems to me we can just handle it in the text and leave bullet two pretty much as is. Insert the word appropriate?

DR. REISCHAUER: Why not do what David said which is apply appropriate quality improvement requirements to Medicare+Choice plans and the institutional providers in the fee-for-service program?

MR. HACKBARTH: I think we're getting close to a conclusion. Do you want to really open up -- yes, you do. All right.

DR. NELSON: I'm agreeing with this, but I think

also to slide that second bullet, with the modified wording, in between the first two bullets on the first page. It seems to me that it flows. And it reduces the redundancy in having both of them right together.

It's relatively minor, but on the other hand, it sets in the first instance what the requirements are for them to be comparable and then plugs in the concept of rewards at the end.

DR. NEWHOUSE: I think this is a text point but it goes back to Carol's point on the handoffs. One of the things the M+C plan can do that the institutional provider can't is try to coordinate across institutional providers. We have this word in this bullet that says comparable. Well, the institutional provider really can't be comparable with the M+C plan on the coordination function.

DR. REISCHAUER: We took that out.

DR. NEWHOUSE: Oh, we took comparable out. So how does it read?

DR. REISCHAUER: Apply appropriate quality improvement requirements to Medicare+Choice plans and institutional providers in fee-for-service programs.

DR. NEWHOUSE: Okay. There's going to have to be a lot of text language on that.

MR. HACKBARTH: I think we're at the point of diminishing returns on this discussion. I think that Alan's point about the order is a good one. That it flows nicely if we take the remaining bullet from the second page and insert it in the middle.

So as I understand it, it would be the Secretary should recognize differing plan and provider capabilities. The Secretary should apply appropriate quality improvement requirements to both M+C and institutional providers in fee-for-service. And the Secretary should reward plans and providers for exemplary performance and improvement.

So I think that's the proposal on the table, with maybe a little editing here and there. Let's do a straw

vote.

DR. WAKEFIELD: Real vote.

MR. HACKBARTH: I want to go back and do them all, but I want to make sure that I'm not missing something. Is what I just said what people want to do on recommendation one? All in favor of that approach? Looks like we've got agreement.

Okay, so why don't we go back and do our official votes? Have we covered everything from your prospective?

MS. MILGATE: The one dangling question I have is the reason we took out comparable was to just have a broader ability to discuss what's appropriate for one or the other; is that correct? I want to just clarify that. Because the purpose of that second one, at least at first, was the comparable.

DR. NEWHOUSE: We said the Secretary should recognize the difference. So in some sense, it then creates...

MS. MILGATE: There was a little bit of a distinction I heard, though, in terms of those that started high and those that started low, and that that should be applied broadly across. I think that there is enough of a distinction.

MR. SMITH: I think the other thing we were trying to do there is emphasize the quality improvement ought to apply in an even-handed way, rather than the level playing field.

MS. MILGATE: Fine. Okay.

MR. HACKBARTH: Okay, let's do our votes. So all opposed to draft recommendation one as amended?

All in favor?

Abstain?

Draft recommendation two, all opposed?

All in favor?

Abstain?

And number three, opposed?

In favor?

Abstain?

Okay, we're done.

DR. ROWE: Glenn, can I make a comment with respect to the text of this chapter for our long-suffering staff, before they depart?

MR. HACKBARTH: Sure.

DR. ROWE: In trying to read this over again with a fresh view, which is not easy after all these discussions, it struck me that in the beginning of this there's a statement which is really at the nub of much of our discussion that says that a concern about appropriate application of M+C quality improvement standards to different types of plans and the differences in quality improvement efforts between fee-for-service and M+C.

And then you have to get to page 23 before you find out exactly what the differences are in the rules. Because then we go into the quality problem and everything

else. We're assuming that the reader understands what the issue is that we have been grappling with of this unequal playing field issue.

So I think that some of the stuff that's on page 21 and 23, particularly the stuff in the middle of 23, there's one paragraph that really explains this difference, should be moved up. That would help the reader understand why is it, what exactly are we thinking about. And then, when we get to the recommendations, it sort of ties together.

It's a minor point, but I think it would be helpful.

DR. WAKEFIELD: Just also a couple of comments of the text, and I'll give you my notes. I like the fact, of course, that you reference periodically AHRQ and its role here. Clearly, I think that this is where AHRQ is the science arm of this endeavor. CMS -- at least it's my view, maybe even in broader areas but in this area, I

think especially -- is somewhat underresourced. So to the extent that we can say here is the entity that can do the evaluation on the demos that might get done, or at least ought to be working with them to do the evaluation rather than having CMS, for example, create the demo, implement it, and maybe evaluate it solo.

So wherever we see AHRQ or an evaluation research component, I think that's a lot to put on CMS. I think the only place where it surfaced, at the last meeting before I walked out, was on that one point about CMS' capacity. I think that's a really important one.

We really ought to drive that point home about the role that AHRQ can play, as not a regulator but on the science side.

Also, you might want to mention, too, that AHRQ has been in the process of developing, with CMS, a CAHPS version for fee-for-service that's going into the field now. AHRQ has been working with CMS, they're not in the field by

any means, but to develop a CAHPS version, a CAHPS-like instrument for nursing home related evaluations. I think that's worth nothing.

I also think it's worth nothing that when you talk about JCHO, JCHO and CMS have pretty much now reached agreement, I think, on some core hospital measures. That's going to drive a lot of what the National Quality Forum does in this area. So there certainly are some wonderful progressions that are occurring on this front.

And because you discuss these areas, that feeding some of this -- this is what's -- we're on the cusp of in those different areas is probably worth noting, and I'll give you my notes on it.

MR. HACKBARTH: We're done. Thank you, Karen and Mary.

Next on the agenda is assessing payment adequacy. We'll have a series of discussions about various services and these discussions, for those of you in the audience,

lead ultimately to our recommendations about updates for different types of providers. Jack and Nancy are going to introduce this.

MR. ASHBY: We're introducing the topic for all of the services. Nancy and I have been switching back and forth and I guess this month it's my turn.

At the last two meetings we have been discussing a model that breaks the updating process for fee-for-service down into two components. As we can see in our now familiar chart the two components are assessing the adequacies of current payments and then accounting for increases in efficient providers costs for the next year.

Today we're ready to try our hands at applying this model for our update recommendations for fiscal year 2003.

Because we have gone over this model at both of the last two meetings, I was not planning to review the steps in detail again. But we did want to stress just a few

points about the process.

The first point we wanted to make is that the approach that we've developed is not really fundamentally different from what the Commission has been doing for years. What it does if formalize separation of the two parts, where before the question of whether current payments were right was sort of implicit or intertwined with the question of the appropriate increase for the next year.

We'd like to suggest that the process might well go more smoothly if we do, in fact, move through the two steps sequentially rather than just jumping right to the update. We have all organized our presentations around doing just that.

The second point was I wanted to try and head off confusion about the very word update. When we say update, we mean the sum of these two component changes that we're presenting in the model here and not just the allowance for cost increases in the next year. In the past, it hasn't

always been clear what a reference to update meant, whether it was accounting for cost increases next year or something broader.

Or to put this another way, when we have seen an update, like for example market basket minus 1 percent as just an example, it wasn't always clear what the minus 1 was supposed to represent, that we expected cost increases to be less than the market basket for some reason or that current payments were too high, or perhaps just that Congress needed savings.

So, at least for MedPAC's recommendations, our hope is that the new system will make it clear why we think that market basket should come with a plus one or minus one, or whatever.

If we could turn to the next chart, I wanted to make a related point here. In this chart, again which should be familiar by now, we have taken the first major step, assessing payment adequacy, and broken it down into

three substeps, I guess you'd call them, that we've conveniently called estimate, assess and adjust.

At the adjust point, we have talked about the possibility of addressing distributional questions in the process. At four different places over the next two days, I believe it's four places, staff will be raising potential distribution adjustments for your consideration.

The thing we wanted to stress is that this is still part of stressing payment adequacy. When we raise these distributional issues we're not talking about expecting one group's costs to increase less than another group's costs in the next year. What we are talking about is the potential conclusion that perhaps payments are more than adequate for one group of hospitals and less than adequate for another group of hospitals, or SNFs, or whatever provider group we're on.

Then, one last clarification. In the box on the left, estimate current Medicare payments and current

Medicare costs. We had some confusion at the last meeting about the word current. We really didn't mean to describe our 1999 data as current. We all sort of suffered with that problem.

What we're talking about here is our best estimate of the payments and costs as of 2002, since our job is to recommend an update for 2003. The last time we had the word measure in this box and it sort of occurred to us that when we're talking about 2002, we certainly are not talking about measuring. At best, we are talking about estimating, not only due to data lags but due to the fact that we're called on to make a recommendation for FY 2003 when we're not even a quarter of the way into 2002.

That's a good lead-in for taking a moment to explain how we did our modeling for 2002 payments and costs. In each case, we began with nearly complete 1999 data. And then, as we see here, we did three different things.

I have to apologize here. I noticed that the

handouts got into reverse order here somehow. So we're on this page.

Three things we did to do our model. One is we applied the updates that are in law for 2000, 2001 and 2002. That's pretty straightforward.

Secondly, we estimated the unit cost increases over that same three-year period. That, of course, is not at all straightforward, especially given that we don't have 2000 cost report data available this year, as we normally would have at this point in the process. So certainly, our estimates have to be seen as having a margin of error around them, mostly the cost side.

We used alternative sources of data to estimate those cost increases where they're available, but basically we only had alternative sources available in he hospital sector. None of the others really offered us anything to work with. Then, when we did not have data, we made what we think is a pretty reasonable assumption that unit costs

would increase at the rate of the applicable market basket. That would apply to all of our sectors for 2002, since obviously that's mostly still future and that's a forecast. It applies to all of the sectors except hospital for 2000 and 2001.

Then, the third thing that we did is model other policy changes that have actually been legislated and were implemented at any time from 1999 on to 2003.

So just to clarify here, we're talking about an estimate of payments and costs for 2002 but we have looked at payments as if 2003 rules were in effect. We thought this was the best way to present the scenario that providers are faced with going into the year for which we are developing updates.

Then quickly, on the last overhead, this lists the six services that we are taking on over the next two days, along with four facility-based services that we're not addressing right now. Rehab, psych, and long-term hospitals

are all on the TEFRA payment system, which is being phased out. There's probably little reason to focus there. ASCs, on the other hand, it's really more of a workload issue. When time permits, we probably will want to assess payment adequacy in that sector as well.

So if there are any questions on the general process we can take that now. Otherwise, we'll move up to the first batter.

DR. ROWE: With respect to the general process, the model that's used or the goal that's used to assess appropriateness of current cost presumably goes back to the goals of the Medicare program. Is that the way it works? You have those here in the text. You don't want to overpay, you don't want to underpay. You want to provide access to high quality care, et cetera.

MR. ASHBY: Right.

DR. ROWE: Is there any consideration in that -- I'm going back to the old argument Judy Lave and I had a

couple of years ago here about what the right number is. Here's where I'm coming from, just to give you my sense. I'm concerned that a lot of these institutions, at least the hospitals, don't have as much access to the capital markets as they used to to sustain themselves, for a variety of reasons. The one I used to run had its bonds downgraded recently, et cetera, et cetera. 70 percent in California have had their bonds downgraded.

So they don't have as much access to capital as they used to. It's not as clear that they're going to be able to sustain themselves so that the Medicare beneficiaries have access to quality care.

Is there any consideration anywhere in the formulas for these kind of economic changes that influence the capacity of these institutions to have capital to invest?

MR. ASHBY: You'll notice on the set of boxes we were looking at we did indeed list the cost of access to

capital as a consideration. To the best of our ability, we're trying to do that. It's a different thing to really assess.

I think that we probably would be best to hold that discussion for this afternoon when we deal with hospitals. That's where the issue has been acute and we have some information to put out. It's a very important thing to discuss.

DR. ROWE: It's just that of all the things on this list, that seems to be the one that is getting worse, more so than some of the others.

MR. ASHBY: Than some of the others, right.

MR. HACKBARTH: Okay, should we proceed with SNFs?

MR. ASHBY: Home health first, I believe.

MS. BEE: The first sector we'll discuss this morning is home health.

As we've just reviewed, the key questions for our discussion this morning are several indicators that I

presented last month that we'll review to assess whether payments are adequate in the home health perspective payment system. Next, we'll add some discussion of how costs are going to change over the next year, and then begin to pull those two ideas together in our update framework.

We do not have cost reports from agencies under the PPS to estimate current costs for this sector. We've used several market factors as indirect measures of the relationship of payments to costs. My first market indicator, according to the OIG, beneficiaries continue to maintain good access to care. This is true for both those discharged from the hospital and those beneficiaries that are entering care from the community.

In the past we have seen substantial movement of providers in and out of this program. However, in the past two years the number of agencies participating in the program has stabilized. Entering and exit have slowed. The fluidity of this market makes entry and exit a reasonable

indicator of the relationship of payments to costs, but I'll note again though, changes in the number of agencies are not a good indicator of the capacity of the home health care in the program.

My last market condition, some observers expected to see an increase in the volume of episodes. Instead, preliminary data suggests that many beneficiaries complete their care in only one episode. And if the per visit payments for very short episodes were too low, we would expect to see extra visits added to avoid low revenue episodes. Instead, the proportion of episodes with four or fewer visits has remained about the same as it was before the implementation of the PPS.

In our overall analysis of these market conditions, we find no compelling evidence that current payments are not adequate.

The next step is to estimate how providers' costs will change between 2002 and 2003. Our default measurement

of changes in the price of inputs used to provide home health services is the forecasted market basket. Changes in the product may cause costs to grow more slowly than the market basket.

Incentives have been changing. The old cost-based system had only weak incentives for efficiency. The cost limits under the IPS encourage better supply use and more efficient travel. Under the PPS, episode payments are the same whether 30 visits or 16 visits are delivered. We would expect the number of visits to decrease under the prospective payment system as we encourage the management of costs within an episode.

On this indicator, as the Commission has noted, the absence of clinical practice standards also constrains our ability to relate differences in service use to failure or success in meeting program goals. Declining use can be indicative of greater efficiency, a shift in care toward restoring independence and away from fostering dependence,

or a failure to meet the needs of the chronically ill. It is very difficult to interpret this data.

The preliminary data that we have seems to suggest that visits per episode have been declining under the PPS.

In HCFA's PPS demonstration, prospectively paid agencies significantly decreased the number of visits per episode compared to agencies still paid on costs. However, prospectively paid agencies in the demonstration also increased their costs per visit. This corroborates anecdotal evidence that visits under the PPS are longer, maybe more expensive visit types are replacing less expensive ones, an increase in the use of therapy and a decrease use of home health aid, and the use of non-visit services such as remote or telehealth monitoring or advanced wound care techniques have increased.

Thus, decreasing visits per episode will lead to decreased costs per episode only to the extent that it is not offset by rising costs per visit.

In the face of such uncertainty regarding both the current relationship of cost and payments and likely changes in costs, market basket could be an appropriate update. The update in current law for this sector is market basket minus 1.1, which we could also find is within a range of appropriate update factors.

My last slide brings two policies to your attention that both have payment implications for this sector. The so-called 15 percent cut currently scheduled for October 2002 is the last phase of a process begun in the BBA of 1997 to reduce spending on home health services. If implemented, this policy would reduce the base rate of the PPS.

The legislation which started the transformation of the home health system was conceived in an environment of high and escalating home health spending. The changes were intended to reduce spending and redirect the benefit towards shorter, more intense episodes. Our data seems to indicate

that providers have responded to the policy changes.

Total Medicare spending on home health fell 52 percent from 1997 to 1999. Fewer beneficiaries per 1,000 Medicare beneficiaries use home health. The volume of visits per user has decreased. Total average home health length of stay has declined. And the proportion of home health users who use therapy, a relatively intense service, has increased and the use of home health aides, a relatively low intensity service, has decreased.

So we now have much less spending on a home health benefit that seems to provide more intense services in fewer days to fewer people. Without clinical standards or a clear definition of the benefit, we still cannot know if we've achieved the long-term goal of buying appropriate services. However, evidence suggests that the short-term intent of the process begun in the BBA has been substantially achieved.

The options that we could consider regarding this policy would be perhaps to eliminate the cut or to postpone

the cut.

The second policy with substantial payment implications is the 10 percent add-on. BIPA legislation has provided a 10 percent higher base rate for home health services provided to beneficiaries who reside in rural areas, which is to say outside of MSAs, since the implementation of the PPS. This add-on is scheduled to sunset in April of 2003.

In June of this year, the Commission concluded that the new PPS should work equally well in both urban and rural settings based on our analysis of the components of the PPS. And we have no evidence that PPS payments generally are not adequate relative to costs.

However, in June we thought it was possible that rural costs per patient could be higher than urban costs due to small-scale of operations, the distance traveled between patients, and differences in the use of therapy.

We do not have measurements of payments and costs

in rural areas but we do know this: discharge planners at urban and rural hospitals were able to place Medicare beneficiaries in home health at similar rates.

We have no data on the volume of care in rural areas since 1999. However, the number of home health users per 1,000 beneficiaries declined significantly more rapidly between 1997 and 1999 in rural areas, down 26 percent, than it did in urban areas, down 19 percent. And the rate of exit of agencies in rural areas was greater than that in urban areas.

Again, we have no evidence to suggest that payments are over adequate or inadequate for the system generally. It is possible that costs differ in rural areas but we have no measurement of rural payments and costs. Given this uncertainty, it may be appropriate to continue the add-on payment for one more year.

The two options we could consider regarding this policy are that the rural add-on not be allowed to sunset in

April of 2003 but be instead extended for one more year. This you could characterize as a risk-adverse option. If we wish to be cautious about reducing payments by 10 percent without evidence about the current adequacy of payments, we may urge the extension of the add-on.

Option two would be that the rural add-on should be allowed to sunset as currently scheduled, in April of 2003. On the other hand, we have argued against special payment provisions of just this sort. If there are shortcomings in the PPS, we should diagnose the malady and cure it, rather than apply a one size fits most bandage to the symptoms.

This concludes my prepared remarks and brings us to the action items for our discussion today on this sector. Staff asks the Commission to consider recommendations on the adequacy of the base rate, the update factor, the 15 percent cut, or the rural add-on.

DR. LOOP: This is an informative chapter. I

thought your conclusion about the base payment being adequate is possibly premature because we are only at the end of the first year of PPS and you point out, in the text, that you don't have cost reports from agencies under PPS to estimate the current costs.

So what I think you're saying is in the absence of data, everything is fine. And I'm not sure that's correct. I'd like to hear from Carol, who's the real expert in this area.

MS. RAPHAEL: As I step back, my main concern is that we try to maintain some stability in this sector. I think you have to look at the last three years, where we went from a cost-based reimbursement to an interim payment system, to a prospective payment system with no transition at all provided.

And so my own view is that we need to do watchful waiting and not draw any conclusions at this juncture or do anything that would further destabilize this sector.

I think that you're right, Sharon, in making the point that Congressional intent was to try to change the incentive so that volume would not continue to increase and to try to restrict the benefitting carve-out to some degree, the part that was perhaps attributable to long-term care supportive services. And we, in this Commission, should be encouraged by the fact that we were worried about stinting and attempts to try to utilize the fact that you could have unlimited episodes and this LUPA or short visit portion.

And the preliminary data, in fact, indicates that, as Sharon pointed out, 90 percent of the patients getting care in the top diagnoses are getting it within one episode. And what was estimated to be the percentage of these short visits is, in fact, very close to what we're seeing. And people are not giving someone a fifth or sixth visit in order to bump them into the higher paying episode. So I think that all, for me, is quite remarkable and reassuring.

I think that are some dynamics that are important

here. One is that all of us have had to invest in technology and many organizations don't have access to capital to make those investments in technology, because we had to do a system for interim payment, a system for something that I won't even go through which is quite esoteric called sequential billing. We had to do a system for prospective payment.

So in the course of three years, we've had to implement three major billing systems that are quite costly. I think that is an issue for the sector. In addition, I don't think we know enough about what's happening to the mix of visits. We know that visits are declining. All early indications lead us to that conclusion. But we don't know exactly what the components of the new episodes of care. And we also don't know exactly how long these visits are, what has happened to productivity.

I think there are issues in the home health sector that are different from some of the other sectors, because

it is hard to substitute service. I mean, there's a lot of talk about telemonitoring. My own view is that is not in widespread use. It has not gone through diffusion yet. It's sort of a few boutique programs.

We can't substitute licensed practical nurses and nursing assistants to the same degree that other sectors have. So I think this whole issue of substitutability needs to be examined in much greater depth.

So my own kind of sense on all of this, at this point, is that we shouldn't jump to quick conclusions, that we should keep kind of watching and monitoring how this evolves.

MR. DEBUSK: I think there's something else here we might take note of. In the post-acute area, we've come up with some prospective payment systems that have not been too successful. And here, this OASIS system which has 80 categories, I'm sure there's some further refinement but there might be a chance that we've done something pretty

close to being right here.

We might take note, as we go forward at looking at these other systems in the form of assessment and maybe expand upon some of this for this post-acute area.

So all in all, I think this has worked pretty well. But I think we should stay where we are at. I don't think we can stand to cut at this point. I don't think we need to break it if it's not broke. We need to take a further look.

MS. BURKE: Two things. One going to Carol's point. I think I absolutely agree with what she has suggested about the need to allow some stability to occur for a period of time. I wonder if, in fact, we might not comment in the text on that fact. Not only do we not have the data to be able to make an adequate decision on an adjustment but, in fact, what the sector has dealt with over the last three years in terms of the implementation of a variety of systems that have had an impact on that

particular sector, I think we might in fact comment on that specifically.

I also worry, frankly, as I look at what we'll have to look at going forward, as to whether or not in fact we believe that within a year -- because the comment is to delay for a period of time -- whether we think a year, in fact, is going to be adequate to give us the information necessary to make a decision both on the cut as well the rural adjustment.

My experience, old as it is, is that it never happens as quickly as we anticipate and the data is never very good very quickly. So I wonder if, in fact, we ought to say that there isn't going to be this issue of whether or not the data is going to be adequate within that period of time, whether we'll have enough on the books. My guess is we won't, but I wonder if we might not make a comment on that as well, as to how quickly.

Because again, I think the sector needs some

stability for a period of time, which is not to suggest you want to pay at an inappropriate level for any extended period of time. But I also think we do tend to rush to judgment and it's not clear to me how quickly we'll get that kind of information, for the reasons that Carol suggests.

MR. HACKBARTH: Sharon, any reaction to that point? It makes a lot of sense to me.

MS. BEE: I guess my question would be would the recommendation then be for some kind of postponement in a unit larger than one year? Does that move you toward thinking about eliminating the 15 percent cut as a recommendation? How far down that road do you want to go?

MR. HACKBARTH: My thinking about it would be not to eliminate it entirely, but stretch it out for what we think is a reasonable period that will allow us to evaluate these things. I don't know if that's two years or -- but to every year come back and say is this the year that we're going to have the 15 percent cut doesn't appeal to me as a

process.

DR. NEWHOUSE: I was actually coming from much the same place Sheila was but I was going to see her and raise her one. I don't have any confidence that in a year, or even two years, we'll be in a much better place. I have not problem with postponing the 15 percent cut and postponing the rural sunset provision.

But I thought we ought to add a recommendation here, and probably in the SNF chapter and maybe some others as well, that probably AHRQ should be given some money to research standards in this field. I mean, home health has been incredibly labile, as we all went up like a rocket and then down like a stone. Nobody seems to have much of a clue about what happened during all that period.

I think at the rate we're going, we're likely to be in that position downstream. So to get us out of that box, and I think it will take a few years, we need to put in some kind of recommendation for research on judging

performance, adequacy, however we want to couch the words. But the idea is to essentially implement Jack's box on judging changes in the product. I don't think we know what we're doing here.

DR. REISCHAUER: Just as a matter of interest, when we have suggestions like this it would be nice to know how many billions of dollars we're talking about. But having said that and made myself appear to be a budgeteer, let me say that I would go one step further than either of my two esteemed colleagues, and I would say it's time to recommend eliminating the possibility of the 15 percent.

I see no evidence here that we could be anywhere near 15 percent overpaying these entities. If we're overpaying them, and I kind of think from what I read in the tea leaves that that isn't the case, it's a percentage point or two. And isn't that what this new framework is supposed to pick up later on? So why add uncertainty? Let's just bite the bullet and make a recommendation saying no 15

percent cut. And then if it turns out well, that was a little bit wrong when we come back three years from now or two years from now or whatever, it will show up in this new framework as a base payment that's a little out of whack.

Going on to the base payment discussion, which Joe started, I was going to say something when Jack was up there about this framework. That is that I think one of the questions should not be sort of product but quality, because for some of these sectors that we're talking about like home health, in effect, Medicare is the game for all practical purposes. You lower the payments and costs are going to come down. By definition, there's nowhere else for them to go.

We can look at access but one access is one dimension of a multi-dimension output. The other dimension is quality really. The quality can be deteriorating and it's highly likely that we can't say a whole lot about it, but we should at least make the world aware of it, that this

is important.

MS. BURKE: Bob raises quite a good point because presumably there's been some adjustment in the baseline. What, in fact, did they carry in the '02 baseline for the 15 percent? And do we know what they carry in the '03 for the 10 percent?

MS. BEE: I can certainly bring you the estimates that we have on this.

MS. BURKE: Somebody will have to eat that, we may as well know what it is.

DR. ROSS: It will be revised between actually now and when we meet next, to set new baselines.

DR. REISCHAUER: I don't think that should affect our decision, but it just might mean that we know how much armor to put on when we make it.

MR. HACKBARTH: Any other comments? What about the rural piece?

DR. REISCHAUER: I think there's a lot of reasons

in that situation to say, continue for a year or two until some more information comes in, as opposed to the other.

DR. WAKEFIELD: Can I just be on the record to affirm that good point? I hate to lead on rural. You notice that I stepped back or sort of stayed in the weeds. But I'm with you, Bob. I want you to know that.

DR. REISCHAUER: I figured I was your front guy.

[Laughter.]

DR. ROWE: I agree with Bob's recommendation but I want to make sure I understand the logic here so we don't get into a trap. I want to make sure we're not saying that we're early on in our experience, we're in a data-free environment, we really don't have enough data to assess the appropriateness of the current payments. And based on the data available to us, we therefore decided that we don't want a 15 percent cut because we can't both have the data on the one hand and have enough data to indicate that this cut is not appropriate on the other hand.

So we need some bridge between those to make sure that we are making a statement that says that even though the data are early and incomplete it's quite clear, based on them, that it's highly unlikely that a 15 percent cut would be appropriate. Is that what you're saying?

DR. REISCHAUER: I don't think it's true that we have no data. I mean, we have data through June of this last year on numbers of agencies on visits, on things like that, which would be flashing red lights if we were paying 15 percent too much or 20 percent too little. That's all I'm saying.

DR. ROWE: I think that's what I'm saying.

DR. ROSS: I just wanted to weigh in with Bob on that. The 15 percent is a big number. When things are off by that much, you will see entry, you will see other changes. And it falls on the heel, as Sharon said, of a 50 percent reduction in spending. Those are big changes.

MR. HACKBARTH: Just for my information, the 15

percent cut is from an old baseline. So it would actually be a 6 percent cut, if I read the material, from current levels; is that right?

MS. BEE: We'll get an updated estimate from CMS on what that would be. They're right now working on plugging in the most recent data available to make that estimate. But that's correct.

MR. HACKBARTH: Roughly, something like that.

MS. BEE: That's my impression.

MS. RAPHAEL: I just wanted to reaffirm what Joe said. I do think we need to look into this further. This 52 percent drop in expenditures in the course of two years, and the drop of beneficiaries per 1,000, needs to be explored. And we really need to gain some better understanding of what is going on.

Because once again our main measure of access is talking to discharge planners in hospitals. We know 38 percent of the people who come into the system come in

through physicians and the community. We just really need to have a better sense to just feel confident that access is not diminished in this area.

MR. HACKBARTH: We still need to do the SNF piece in the next 25 minutes. Have we gotten to a point on home health that you, Sharon and Murray, have what you need?

MS. BEE: Yes.

MR. HACKBARTH: Okay, so what I'd like to do is move ahead. Thanks, Sharon. Sally?

DR. KAPLAN: Now we're going to talk about SNFs.

At the end of my presentation on payment adequacy, you'll need to give me a sense of the direction of your decisions, where you think you're going. There are four decisions that you need to make between now and the January meeting, or between the end of January meeting.

First, whether the base payment is too high, about right, or two low. Second, you'll need to decide whether the distribution of payments is appropriate between

freestanding and hospital-based SNFs. If you decide the distribution is inappropriate, you may want to do something about it. And finally, the update.

We'll stop for you to discuss the decision points on payment adequacy before we talk about the update for fiscal year 2003.

In deciding if payments are adequate, we first ask if costs are appropriate. SNF costs were very high under the cost-based payment system. There was rapid growth in Medicare spending for SNF care from 1990 to 1996, averaging 23 percent increase per year. Most of this increase was due to growth in ancillary services for which SNFs were paid on a cost basis. Both the GAO and the OIG have consistently maintained that costs were overstated during this period.

Under the PPS, SNFs had room to cut their costs and they apparently did, by renegotiating contracts for therapy and drugs, by substituting low-cost employees for higher cost employees, and by cutting therapy staff.

Freestanding SNF costs appear to be appropriate. Their costs per day decreased from $305 per day in 1998 to $240 in 1999. Hospital-based SNF costs, however, are much more difficult to interpret. Hospitals have historically allocated costs to their SNFs, making those costs overstated. How much those costs are overstated is not known. The estimate on hospitals' cost allocation to outpatient departments is 15 to 20 percent, but we don't know whether hospitals allocate more, less, or the same percentage to SNFs.

Jack described pretty much what we do in modeling, but I'd like to bring up several points, because we're considering an update recommendation for fiscal year 2003. We've also considered four payment policy changes scheduled to occur in that year.

First of all, SNFs will be paid at 100 percent federal rate in 2003, which is the end of the phase-out. We included the temporary rate increase that remains in effect

until the RUG-III classification system is refined. That is 6.7 percent increase for rehabilitation patients and a 20 percent increase for medically complex patients.

We did not include two temporary rate increases that expire in fiscal year 2003 under current law. That's a 4 percent increase across the board and a 16.66 percent increase in the nursing component base.

I'm going to show you the results of our modeling, but I want to point out that margins would have been higher in 2000 and 2001 than in either 1999 or 2002 because of these two additional add-ons. But those margins will not be reflected in the table you'll see next.

MS. BURKE: Sally, could you repeat that again?

DR. KAPLAN: We don't have 2000 and 2001 on this table that you see right there, and they would have been higher, margins would have been higher than either in 1999 or in 2002.

DR. ROWE: Because of these extra payments.

DR. KAPLAN: Because they have these extra bump-ups that are not included in 2003.

On this table we show margins for 1999 and three estimates for 2002. The first estimate uses costs as recorded by SNFs. The next one assumes that hospital-based SNFs costs were overstated by 20 percent. And the third one assumes that hospital-based SNF costs are overstated by 30 percent.

The situation is full of uncertainty. We know that hospitals allocate costs to the SNFs but we don't know how much. How much they allocate, however, has a big effect on the overall SNF margin. Even with this uncertainty, however, you will have to decide whether the base rate is adequate.

The other factors that we examined, besides the margins, do not suggest that the base rate is inadequate. The IG found that beneficiaries have had stable access to SNF care in 2000 and 2001. Freestanding SNFs have stayed in

the program. In contrast, over 400 hospital-based SNFs have dropped.

Our best estimate is that overall estimated margins range from between zero and 3 percent, depending on how much hospital-based SNF costs are overstated.

DR. ROWE: Is that Medicare margin?

DR. KAPLAN: Yes, it's Medicare margin.

Is the distribution of payments appropriate? The margins suggest that the distribution is not appropriate. Payments are more than adequate for freestanding SNFs and less than adequate for hospital-based SNFs. 20 percent of hospital-based SNFs have left Medicare, which also suggests that payments are less than adequate.

There are several reasons for the difference between hospital-based and freestanding SNFs. First of all, we've already talked about the cost allocation. Second is the classification for the SNF PPS. The RUG-III is based on a patient assessment instrument that does not collect the

information needed to account for the needs of the more acutely ill patients found in SNFs. Also, the RUG-III does not appropriately target payments to the costs of providing SNF care, especially to patients needing costly ancillaries.

In our analysis of APR DRGs last year, we found that hospital-based SNFs case mix index was 11 points higher than freestanding SNFs. We don't know how much of a difference in costs this represents.

Another difference between freestanding and hospital-based SNFs is staffing. According to a study by CMS published last year, hospital-based SNFs have much higher staffing, more licensed direct care staff than freestanding facilities.

If you agree that the distribution of payments is inappropriate, then you need to decide whether an adjustment is warranted. The best way to fix a distribution problem caused by the classification system is to fix the classification system. However, that is easier said than

done, as CMS has demonstrated.

CMS' attempt to refine the RUG-III in 2000 failed. That failure, in part, resulted in our recommendation that CMS develop a new classification system. However, 2006 would be the earliest that a new system would be available.

A temporary fix might be to have different updates for freestanding and hospital-based SNFs. However, that would translate to different basis and different basis might be a solution that would not be temporary. Politically, it is sometimes very difficult to get rid of temporary fixes to payment systems to begin with, and especially if they're in the base.

A third alternative, which is not on the slide, would be to use Congress' method, and that is to have an add-on for hospital-based SNFs. That would be easier to eliminate because it wouldn't be in the base.

I'd like you to discuss payment adequacy before we move to talking about the update, and that is whether the

base rate or pool of money for SNFs is adequate, whether the distribution of payments between freestanding and hospital-based SNFs is appropriate, and if not, what should be done about it. Then we'll talk about the update.

DR. ROSS: Sally, I'm going to suggest to you, just because of the time, just go through what the market basket and current law --

DR. KAPLAN: Okay. The next slide is just some things you need to know about the update. First of all, any adjustment you decide on will carry over to the update decision. Current law is market basket minus 0.5 percent and the latest market basket forecast is 2.8 percent.

You need to consider whether an update of market basket would be adequate, whether current law is adequate, and all of that in the context of the various uncertainties we've talked about.

The last table in your handout is really to help you think about making your decisions for the update.

That's it.

MR. HACKBARTH: Sally, help me connect some of these ideas. We believe that the hospital-based SNFs have sicker patients. We're unsure how much that increases the costs, but our hunch is that it does increase the costs. In at least some areas, a lot of the hospital-based SNFs are going out of business. We don't think that those sicker patients are having problems getting access to care. We don't see any evidence of that. I assume that means more of them are now showing up in freestanding SNFs and the freestanding SNFs are doing well financially.

Does that mean that the freestanding SNFs are doing a more efficient job of handling a growing population of sicker patients?

There are all sorts of lags in terms of the information.

DR. KAPLAN: First of all, we have case mix for 1999, is the latest year we have the case mix. We don't

have the claims for 2000, the SNF claims for 2000, yet.

I assume that those patients either would go to freestanding SNFs. I can't envision that a hospital-based SNF would necessarily take a patient from another hospital. I would assume, and I have nothing to base this on other than my intuition and having worked in a hospital, that they would take their own patients but they wouldn't necessarily take the high acuity patients from another hospital.

MR. HACKBARTH: Particularly if you're losing a lot of money.

DR. KAPLAN: Yes. The access statistics have stayed basically stable, 2000 to 2001. It is possible that hospitals are keeping patients longer. The hospital length of stay has gone up somewhat in the recent years that we have statistics for.

DR. REISCHAUER: I actually want to come at this a little different way and ask Ralph and Jack a question, which is does it make a lot of sense for hospitals to run

SNFs? Is their cost structure, because of unionization, different agreements with nurses, et cetera, such that to produce the same product is just much more expensive?

And what we see when we change the payment policy is that this was brought home to hospitals, and so we shouldn't worry tremendously if we see the hospital-based SNF capacity of the nation shrink rather substantially because it was artificially high? And does the transfer policy have anything to do with this, as well?

DR. ROWE: My response I guess would be a couple points. One is, it certainly makes a lot of sense based on the financing mechanism because you can imagine a system where a hospital gets a DRG payment for a Medicare beneficiary and then fairly soon into the discharge transfers the patient to a SNF bed within the same institution and starts collecting a per diem for the same patient.

So from that point of view, to whatever extent

that used to occur, that was a relative incentive for hospitals to have SNF beds within their facilities. I think that's important.

I think there have been some changes with respect to that, particularly transfer policies and other things, which may be at the basis of the reduction in the number of participating hospital-based SNFs that you can see.

From my point of view, I think that the major reasons to have them were clinical. That is the physician who was the primary physician, who may have operated on the patient's hip or heart or something, was able to continue to see the patient in the SNF. That rehabilitation programs, which are very important programs, that inpatient acute rehab, would also be able to be established in the SNF area and treat those patients and use the same, in fact, facility for the rehab that the patients could be transported to.

There were these programmatic, clinical supervisory reasons which really improve the quality of

care, were very physician friendly, and made these kinds of units very attractive to have within the facility. That's my thought. Ralph?

MR. MULLER: I would build on that in part by saying that the intellectual model of the last eight, nine years of trying to have integrated systems and avoid some of the difficulties of hand-off of patients from one setting to another, which we all know are very difficult to execute in practices versus whatever one might think in theory, cause people to try to control as much of these production processes as they could, even though the cost structure may have been inappropriate and unwieldy when you have the overhead of a hospital being allocated to a SNF. So I would second what Jack has pointed out.

I would also say that insofar as one thinks one is losing 50 percent on it, people will get out of that business very quickly, no matter what their concerns about integration, because you can't afford to lose 50 percent of

margin.

I want to add to that, though, by saying there's this assumption that you must be around a lot more sophisticated hospitals than I've been around where these people allocate costs right and left, back and forth. You have to ultimately have your costs add up to 100 percent on a Medicare cost report, so this notion of people moving back and forth.

Now I want to say if, in fact, costs have been, in that sense, over allocated to SNFs and now these astute hospital executives will start allocating them more appropriately, that will add costs back to some other program, most likely the inpatient program. And that should affect our discussion later about maybe there's costs there that are coming back to the inpatient program that are understated. So we have to look at that in a symmetrical way.

I do think it's fair to say that within this exit

of hospital-based SNFs, it may not be as quick as the exit of home health, but it will continue to occur at these kind of negative margins. So I think we do have to look and see whether there's a programmatic reason, as Jack indicated, to have these patients have access to this care.

I think there probably was too much of an incentive to go that way financially that added to the clinical imperative that Jack mentioned, and it may go too far now if we take them all away.

DR. WAKEFIELD: I have three comments. First of all a comment on the text under the appropriateness of costs. You've got some good references about how SNFs have been able to cut costs by substituting lower cost labor for high cost labor. I think all in all that's always a good thing when it can happen, and there's not an accompanying decline in quality of care. Which isn't to suggest that there is, but there is the other side of that, the flip side of that picture. I'd always kind of want to have, to the

extent one could, an ear toward that.

This by itself, doesn't necessarily speak to me as a good thing for a Medicare beneficiary. It might be exactly a good thing, both in terms of lowering costs and maintaining quality, but if we don't know the flip side of that, that's always a bit of a concern to me and something that's hard to get at. But keeping your finger on that side of the equation, I think, is important. By itself it doesn't make me feel terribly comfortable.

Secondly, I thought that the margins data on table two, obviously in terms of rural, are a little bit disconcerting, especially hospital-based rural margins, and even freestanding. It's good, at least it's in the positive side. But they're not walking away with a bank here, it would seem to me.

The last comment that I wanted to make is with regard to relying on the IG's querying of discharge planners and their ability to access SNF services for Medicare

beneficiaries, I may think that is about the best we can come up with. And that is they say that generally speaking there's not a problem.

But I'd say again, from a rural side, just a question that nags a little bit at the back of my head. Would this still be the case if we asked that question of Medicare beneficiaries, for example rural Medicare beneficiaries? That is, do they have good access? They might have access. Is it anywhere near where they live? Is it in a town near where they live? Or is it the fact that a discharge planner can put them in a SNF, but it's not something that's available to them in some geographically reasonable area?

It's just trying to look at that question a little bit from the beneficiary side. I certainly don't know the answer to that. I'm just saying that the discharge planning piece probably gives us one part of the picture, and there may or may not be another part to that picture.

DR. LOOP: I think the reason that large hospitals still have SNFs is because of the clinical follow-up. I think Jack's answer is correct. But the reason they also lose money is that the severity of illness is a lot greater in hospital SNFs.

So maybe we should recommend that through the APR-DRG system we add that CMI rating to the RUG-III to try to differentiate the type of patients that are in freestanding versus hospital-based SNFs so that we can reimburse the hospital-based SNFs if, indeed, their severity of illness is worse.

DR. KAPLAN: I think that may be one of the alternatives that they're investigating for a new classification system. The difficulty is it wouldn't happen until 2006 at the earliest.

DR. LOOP: Why would you have to wait? Out of curiosity, why do you have to wait until 2006? I mean, there may not be too many more hospital-based SNFs by 2006?

DR. KAPLAN: I think it takes several years to get a new system in. And they're still just at the beginning of testing alternatives. They just started on that this summer. I'm just trying to make you be realistic that we're not going to see anything before 2006. It's actually fiscal year 2002, now. The report to Congress is for January 2005, so we figured a year after that.

DR. ROSS: Sally, I think Floyd's point was, could you do something blunter in the interim, which is what the Congress tried to do in the last couple of rounds of legislation, although it's worth noting that the first time they did this to try and attach money to the medically complex and most expensive categories of patients, by the time the legislation was done they had expanded that list not quite across the board, but the amount of money they had to spend essentially got diluted across many more categories.

It may be worth revisiting that, and asking if

shrinking that number of categories might be a crude proxy for getting at the higher case mix.

MS. BURKE: Sally, I just had a factual question to ask. To what extent are swing beds still in place and play a role in this at all? They're rural. They're an odd sort of connection to many of these smaller hospitals. Access and issues have always been traditionally a part of what we look at in that context. But to what extent do they play in any of this?

DR. KAPLAN: I think they play in the access issue. They really don't play in the PPS yet. They will be in the PPS as of July 1 of next year, 2002. And they will be paid under the PPS.

My understanding is they will be advantaged by being paid on the PPS on that basis.

MS. BURKE: Just to close the loop. At some point we ought to think about the broad application of all these issues with respect to SNFs and what happens with those

units as well, and what if anything we want to say about that. It's a very small universe, but for the people that have them there, sort of a critical component to this delivery system.

MR. HACKBARTH: We're down to our last few minutes now and I want to make sure that we give Sally what she needs to prepare for the next meeting. So if we can keep our comments brief, that will be helpful.

MR. MULLER: When the post-acute alternatives diminish, whether it's through these hospital-based SNFs or home care and so forth, one alternative clinically is obviously also to keep the patient in the inpatient setting, which discharge planners do because that's the safest alternative for them. So one thing, again it may take a while for us to see that, but certainly in my most recent U.K. experience I really see the effect of not having post-acute care. They stack up the hospitals.

So I think one thing we have to be sensitive to in

looking at this, if these trends continue in any way, is there a kind of stacking up at the end of stay rather than going to the post-acute setting?

MR. HACKBARTH: Strictly on this point?

DR. NEWHOUSE: It's kind of where we're going. Because the consensus, as I heard it, was for more money for the hospital-based SNFs, but I think we need to have some discussion of what magnitudes we're talking about, if that's where we're going.

MR. HACKBARTH: In fact that's the last piece I wanted to get to.

DR. REISCHAUER: One of the things both Sally and Sharon asked for guidance on was the update since the base seems to be okay, maybe except hospitals. We didn't talk at all when Sharon was here about the market basket minus. And the minus for home health was 1.1 percent. The situation for SNFs is 0.5 percent.

I'm wondering about the logic of having different

minuses here. I presume this relates to unmeasured and unobservable productivity improvements. If I were sort of ranking industries or whatever sectors by potential for productivity improvement, it would depend very much on how technologically oriented, capital versus labor oriented, they were. And home health would be down near zero, as far as I was concerned. SNF would be a little bit above it.

Do you want us to talk about that kind of thing?

DR. ROSS: You're greatly overestimating where those two nicks came from.

DR. REISCHAUER: I know they have to save money, but I mean, we're trying to do this in a rational way going forward, right? Not to preserve irrationality, right?

MR. HACKBARTH: They are artifacts of the Congressional budget process, as opposed to estimates of productivity improvement, as you know better than any of us.

DR. REISCHAUER: For which I claim total innocence.

[Laughter.]

MR. HACKBARTH: So I interpreted the fact that we weren't dwelling on them was just a recognition of their origin and that we ought not be driven by them.

DR. REISCHAUER: But if they're crazy, then they create a problem with the base payment in the year or the year after. So maybe we can solve the problems before they arise, rather than after they arise.

DR. ROSS: I think in both of these settings, the elephant in the room is not the minus 1.1 or the minus 0.5. If you look at home care, it's the 15 percent, or whatever it will turn out to be, payment change scheduled for next year. And if you look at SNF care, if you look at the margins that we've presented, it wouldn't seem that minus 0.5 is going to be the story in that, in terms of payment adequacy.

DR. REISCHAUER: I'm just trying to make myself

Carol's most favorite commissioner.

MS. RAPHAEL: A couple of points. Sally, as I recall from a study that was done last year, and I'm wondering if you can just update us. I have three points to make.

The first is I seem to recall that there had been a study that showed there was no significant change in case mix over the last decade in nursing homes. No? Am I...

DR. KAPLAN: I'm not familiar with that study. And are we talking about nursing homes or SNFs?

MS. RAPHAEL: SNFs. Was there any work done taking a look at the mix of patients in SNFs?

DR. KAPLAN: Not that I'm familiar with. Other than what we did, which was the APR DRGs, which was strictly SNFs and it was using the APR DRGs. And we showed that case mix went down from 1995 to 1999 a little bit.

I mean, it wasn't radically different. And that the difference between the hospital-based SNFs and the

freestanding SNFs case mix, and also we had swing beds in that as well. But the difference between the hospital-based and the freestanding was 11 points. That was 11 points in 1999.

MS. RAPHAEL: I just wanted to try to remind myself of that study.

I personally believe that if we're going to have any add-ons for hospitals and we believe there's some value in trying to do that in the absence of an accurate assessment system here, I think it has to be tied to case mix, it's my own view, some way of measuring the case mix difference and having it tied to that. I don't know how to accomplish that.

But I think we just don't know enough on an ongoing basis about what's happening to case mix here. I see some changes in the composition of the SNF population myself in the last year or two, but it's hard to demonstrate what those changes are. So I kind of feel that we have to

think about how we're going to try to demonstrate, if we're going to do any added payment how that is, in fact, buttressed by some clinical rationale.

The other thing I was going to ask you is when we've looked at hospitals we've looked at Medicare margins and we've looked at total margins. You gave us information on Medicare margins. We've received a good deal of information on total margins, which show a different picture.

I was wondering if you could comment on whether or not you do look at total margins and any influence they have in these considerations?

DR. KAPLAN: Deborah ran the margins for 1999 and she was unable to get any sense out of the total margins for the nursing home, for the freestanding SNFs. I want to revisit that again, but I haven't been able to find time to do that yet.

Basically, I know what the industry is saying,

which is that Medicaid is very low paid. And I'm sure that in some states it probably is. I'm not sure that that's true across all 50 states. I think New York is well known for being generous in their payments.

MR. SMITH: We may need more time here, Glenn, because it seems to me we need to return to Floyd's request to try to design a blunt instrument and I think Carol wanted to go in this same direction.

The clinicians make, and I think in the paper Sally made, a convincing case that part of the cost difference is rooted in clinical issues. The case mix index differences and the comments that Floyd and Alan and Jack made, that's appropriate for us to try to figure out how to respond to. I don't know what the blunt instrument is. You suggested at the end of your presentation that it might be an add-on. Carol says we need to figure out what's the right metric to measure the add-on with. I think we need some more time with that. But it seems to me that's where

we ought to head.

The argument has been made for distributional change, but we haven't spent enough time on what's the way to get that done.

MR. HACKBARTH: Let me see if I can summarize where we are. Looking at the table here, what I hear is a consensus that there probably is a financial issue with the hospital-based facilities. Because of cost allocation issues the exact magnitude is uncertain, but there seems to be a sentiment that it's real.

Even if it were true at one point that we had too many hospital-based facilities pre-transfer policy, there are legitimate important clinical reasons for them to continue to exist and we can't just happily watch while they disappear.

If we provide some special assistance, it ought to be in the form of an add-on, as opposed to something baked into the base forever more. And we need to target it as

best we can from a clinical standpoint to the patients institutions in need.

I hear consensus around those points. Am I hearing correctly?

MS. BURKE: Glenn, I guess one question that I would ask, the decision to do an add-on rather than to adjust the base, there appears to be a fairly fundamental issue here with hospital-based units that doesn't seem to be temporary unless the case mix dramatically shifts.

So my question is why the add-on and why not a base adjustment that then doesn't become an ongoing sort of set of targets of let's just do away with the add-on this year?

MR. HACKBARTH: My thinking on that, Sheila, was that at some point down the road, hopefully before 2006, we'll have a new system. And so ideally, that's the way to fix this problem. What we're doing is trying to fix it between now and then, and an add-on seemed to be

appropriate.

DR. KAPLAN: Then what I hear you saying to me is you want us to come back next month with a blunt instrument that somehow is clinically targeted, okay? Is that right? I have something in mind but I'd like to discuss it over with peers.

MR. HACKBARTH: Thank you, Sally.

MR. DEBUSK: Last word. Realizing that there's a real need here, there's no doubt about it, but the hospital affiliated SNF or owned SNF represents 3 percent of the total pie. There's 97 percent out there with that stand-alone that's got some major issues and some major problems as we go forward. So at our next meeting, I think we really need to get into -- and I'm sure you will -- but there's some major issues there that we're certainly going to need to address.

MR. HACKBARTH: I think, at least from my perspective, the reason the conversation focused on the

hospital-based is captured in the table, that the freestanding, based on the best information we have available, look like they are doing, on average, pretty well.

MR. DEBUSK: But there's something like $58 or $60 per day that's going to sunset in the future, and I think if that truly sunsets, I think it's going to create some havoc in the industry because this Medicaid, the states are in trouble now, we know they're in trouble with this thing. It just won't go under the rug. It's going to be there, and right now Medicare certainly helps the existence of this piece.

MR. HACKBARTH: Just one question about the table. For the freestanding projection for 2002, that includes an estimate of the loss of the money that disappears in 2003. So this is 9 percent after that special add-on disappears?

DR. KAPLAN: Yes. Those two add-ons disappear, not the add-on that is due to the refinement of RUGs.

MR. HACKBARTH: We need to call a conclusion to this discussion for now and we'll look forward to January.

Now we will open our public comment period. Please, we've got a limited amount of time available, namely 15 minutes. Please keep your comments brief. And if you hear somebody before you make the point you were going to make, why don't you consider it made and we'll move on.

MR. GREENBERG: I'm George Greenberg and I work in ASPE, Assistant Secretary for Planning and Evaluation, at HHS. I had a couple of thoughts, I hope these are factual.

I don't believe the 2006 year simply because that add-on is $1.4 billion, I think, and we're under a lot of budgetary pressure to do something by next October. Whether that actually happens or not, given the ability to do intelligent refinement in this area, I'm not exactly sure. But I just want to point out as a fact that the administration is looking at that money and wants the Department to make the change. And there are people in the

Department who want to make it, too.

Another point about 2006 is the Department is also working on an integrated post-subacute care payment system and I would hope that by then we're not talking about all these different stovepipes of separate reimbursement systems, but we may have assessment instruments and others that look across the entire sub-post acute area and it may be a different discussion by then. So you may want to think about that.

I want to reinforce the comment that where did all these SNF patients go? I think the idea of looking -- I think Sally made it -- of looking back at people staying in the hospital longer should be examined because if that is what is going on I think it's a good thing. 20 years ago we were all upset about administratively necessary days so we developed all of these separate post acute care payment systems and everyone cost administratively necessary days at the average cost of a hospital stay. They don't cost the

average cost.

First of all, you've already paid for a lot of it under the DRG. So if there's someone an extra day it's already paid for, an extra two days. Secondly, you're basically paying for room and board services, hospital services. You're not using a lot of technical hospital technology. And if someone actually needed subacute care, they're in an acute care setting. So maybe the care is better. That all needs to be looked at, I think, as part of the financial picture.

The last comment is I just want to reinforce the discussion that Jack made in response to Bob's point about whether hospital-based care is appropriate. It seems to me although there were a lot of crazy incentives in the '90s, that you had to be crazy not to create a distinct port SNF if you were a hospital because you basically were under cost reimbursement and you could unbundle from the hospital inpatient payment and make more money. There are a number

of clinical reasons, as people said, but you want to encourage integrated care. You want to encourage people who are in the high case mix end of being in an appropriate setting. And I think you reduce transfer trauma if the patient is not being moved across institutions and if hospital inpatient capacity, if we really are over-bedded, it's potentially a good use of the beds.

As I listened to the discussion all of these thoughts came into my head. I just thought I'd try and share some of them.

MR. LAZARUS: Good afternoon. I'm Barry Lazarus and I'm vice president of reimbursement with Manor Care in Toledo, Ohio. I'm representing American Health Care Association.

I'd just like to remind the commissioners that there's over 10,000 proprietary facilities in the United States. They account for 66 percent of all care provided in SNF beds. That equates to about 1 million patients per day

that are cared for in the proprietary setting. So we need to understand and put in perspective that there is an issue with the proprietary setting.

The analysis that the MedPAC staff prepared, I don't believe, presents a good picture of the industry. It's misleading and it's potentially catastrophic in its conclusions. Using this analysis to make recommendations to eliminate the relief that was provided by the Balanced Budget Act and the Budget Improvement and Protection Act really will have a negative and traumatic experience to an already fragile component of our health care delivery system.

The decrease in the payments at this time would really have a dire consequence to the patients that we provide. Many of those patients may be your family members or people that you know. It really will not be a short-term problem. It will be an ongoing problem for many years to come.

We believe, first of all, that the analysis is flawed. It's flawed from the standpoint of the cost report information that was presented after the establishment of PPS is not reflective of the true cost of providing care.

As we moved into the SNF PPS, priorities changed within the facility of having our nursing staff track their costs, track their time in spending services in distinct parts and non-distinct parts, having other statistics maintained. And we've focused our energies on doing a better job, a more complete job in the additional burden of the MDS process and the additional assessments that we had to complete.

Secondly, when you look at a Medicare-only margin, it really misrepresents what's happening within our industry. We're extremely concerned about the body of this financial analysis that ignores the viability and the problems of the industry that we've been encountering. As you probably know, five out of the seven long-term care

companies are in bankruptcy. Some are starting to come out of bankruptcy.

But you also need to understand, and I think someone mentioned, the equity markets. The equity of our industry from 1998 to the first quarter of this year has decreased by 75 percent. The stock market doesn't like what's happening with the SNF industry and there's major concerns.

In addition, the analysis and conclusions do not consider a lot of facts. One is that the market basket only accounted for about 40 percent of the actual cost increases incurred. As the staff uses that market basket update to project costs forward, it's truly understating what the impact of these cost increases will be into the future.

This, coupled with the continued increases in labor costs that we're seeing, mandated staffing requirements in various states such as Florida and Ohio, and liability costs, the prospect of Medicaid budget cuts due to

the economy, the single payer analysis doesn't really portray what's happening.

We believe that the evaluation of the hospital PPS system did, in fact, in the past look at the broader financial perspective of the hospital industry, did take into account the other payers. And Medicare's financing role must be examined within the larger context of the overall payment system. And the inadequacies of not only the Medicaid system but other payers, such as managed care, VA, and to some extent private pay.

Finally, our analysis caused the problem recommendation to utilize a different base for hospitals. As you know in the BBA, Congress decided that the cost of hospital-based units were overstated. They established the basis of limiting 50 percent of the difference between the hospital-based and freestanding costs and they decided that the rates should be paid based upon the patient acuity irregardless of the site.

So now we're talking about going back to a system where there was a differentiation and that the hospital unit cost is greatly overstated. While there may be some arguments to the acuity, we believe that in freestanding SNFs any level of acuity can be provided. Prior to PPS there was what we called subacute care, and we provided a high level of services in the freestanding environment due to changes in delivery systems, due to changes in technology.

The other thing that you all have to consider is the fact that we're working with HHS to develop this quality initiative. If payments are cut, if the add-ons are allowed to sunset, there could be a real impact on the quality of services not only to the Medicare beneficiaries but to all the people that we provide services to.

So I'd like to just ask MedPAC to consider the stability of the industry and concern itself with the adequacy of the payment and overall industry margins and the

access of capital. The payment system must be adequate to provide an appropriate level of quality and access to services that can be provided by an efficiently operating facility and should really make no distinction based on the location.

Again, thank you.

MR. LANE: Larry Lane, I'm vice president of Genesis Health Ventures.

Essentially five quick points. I'm really concerned that the Commission may be basing its actions on some incomplete data and analysis with grave consequences. First off, hospital-based provide only 14 percent of your Medicare days. I do have an analysis that I'd like to share with the Yuden-Oscar data that basically breaks out numbers and percentage of nursing home patients by payer sorts, et cetera.

Second, data. The 1999 cost report file is flawed. We have had great trouble using it. We have

brought that to Commission staff. I know they have made some adjustments in what they've done with it. But the truth of the matter is we cannot come out with meaningful analysis using the '99 data.

But we have looked at though, interestingly, the '95 which is your base year data. Your base year data basically points out that you have a significant bimodal distribution of days. You have 48 percent of the days at $183 a day and 52 percent of the days at $378 a day.

So essentially, looking at that, when you go to an average payment structure you immediately see there's going to be obvious winners and losers. But what doesn't come out in that analysis until you deep dive is what services were they providing and what were the cost of those services?

So essentially we have a payment structure where a margin analysis has been put out using cost data that's flawed without asking the underlying questions of what services are included or not included in that, and which

blends this bimodal distribution across your facilities. And that explains why 1,000 to 1,800 facilities went bankrupt at the same time that there may be 4,000 to 5,000 facilities that had an improvement in their margins in the averaging.

And then finally the point that Barry picked up on is that you cannot just look at Medicare. The real issue here and the travesty is that 75 percent of the residents in nursing homes are paid for by the public sector. And that accounts for 60 percent of the revenue. Medicare is not the driver, Medicaid is the driver. But changes in Medicare at this point, without looking back through at what is delivered, what were the products, and what patients got the service, would in fact destabilize this sector. And I would point out again, 65 percent of your Medicare days are provided by investor-owned, 84 percent by freestanding facilities, or 86 percent by freestanding facilities.

There's a lot at stake that if we destabilize the

sector again, we may significantly disrupt the service delivery structure.

MR. ELLSWORTH: Good afternoon. My name is Brian Ellsworth. I'm with the American Hospital Association, representing about 2,000 hospital-based SNFs and another 1,250 hospitals with swing beds who will also be affected by the decisions you make here.

Let me say a couple of things.

One is length of stay is a key factor here. Our Medicare length of stay for hospital-based SNFs is about half of what the freestanding length of stay is. And so as a result, when you hear a statistic like we care for 14 percent of the days, we actually care for about close to 30 percent of the cases. And that's pretty significant. And that's because our length of stay is shorter, so we're getting the outcome in half the time, which has very specific cost implications. When you're looking at a per diem system it's going to stand to reason that your costs

are loaded higher in a per diem system. But if you look at it on a cost per case basis, our costs are actually significantly lower.

So I would encourage that as one of the avenues that you look at when you're designing the blunt instrument.

The second point I'd make is as you look to refining the system, one of the problems with that -- and we're all for refining the system. But the way the statute is constructed, the refinements giveth and then the statute taketh away the add-ons. That's roughly a washout, at least from our perspective.

So it's not much help. Unless that statutory structure is examined and reconsidered, that refinement by itself just adds money and then takes it away.

Thirdly, swing beds, it was mentioned that they would be advantaged by this. Again, that is with the two add-ons that are scheduled to sunset next year in there, they would be -- according to CMS analysis -- about an 8

percent winner. With those two add-ons taken away they would actually go in the red. So I just thought that that would be important to consider as you're looking at rural access issues.

And finally, I'd make the point that the rates are pretty clearly compressed from a case mix standpoint. The refinement proposal that CMS put forward a year ago pretty clearly indicated that there was a fair degree of compression. The rates that they proposed were much more stretched out than the rates that are current, even with the add-ons. So that is an additional piece of evidence that you should look at that is, I think, very confirming of the analysis that you did with the APR DRGs that both indicate the same kind of magnitude of compression on case mix, particularly underpaying those facilities taking care of medically complex patients.

We're more than willing to work with you to help design how this system should be rectified and I just wanted

to make those points in doing so.

Thank you.

MS. CARLINO: Hello, I'm Beth Carlino. I'm representing NASPAC, the National Subacute Association. I'm also a rural health care hospital-based facility provider.

I'm going to say amen to most of the people who spoke before me and take my cue from saying that I'm not going to repeat everything that was said, but I certainly would agree with most of what was said by my colleagues prior to this.

I would like to remind the panel here that initially when the PPS system was initiated it was called PPS, but truly we don't have an episodic payment. So since we don't have an episodic payment, we really don't understand what our costs are per beneficiary per episode of care, because we've got this disjointed system that pays on a daily basis instead of an episodic basis.

So in order to measure things like how much did it

cost, are we effectively having good outcomes with that cost, the system doesn't allow us to do that. So to keep throwing money at it and to keep trying to adjust what we currently have is simply not appropriate and I would like to indicate that, in fact, the whole system of RUG determination needs to be not adjusted but completely restructured.

The other indication that I'd like to say is that the MedPAC and the Abt study indicated that those systems for payment and reimbursement were flawed. I would just suggest for you that before you determine without adequate information about this episodic payment that you do away with the sunset regulations. You consider the fact that you don't know what the episodic payment and the decreases to that payment are going to really do to the entire industry. And so until you have that information, my suggestion would be that, in fact, we keep those add-ons and keep those dollars because we've already exceeded the mandated amount

that initially was required by the government to save in this industry.

I agree that the burgeoning costs and the escalating costs of 26 percent each year were inappropriate. However, to have taken more than what was mandated away, putting this additional money to it was not burdensome to the establishment.

MR. VERTRASE: Hi, my name is Jim Vertrase. I'm with the 3M company. Just for those who don't know, in addition to Post-it notes and Scotch tape, 3M makes most of the case mix measurement tools that are used around the world.

We have been looking at the issue of creating a case mix measurement system for skilled nursing facilities. I think it's a feasible task.

Our basic philosophy in creating case mix tools is to first create a tool that's useful for management. If you do that right, it will be useful for payment as well. We're

confident we can build a system that's admission-based, that's episode-based, that's severity adjusted, that's based on -- for the classification and the severity levels both -- are based on diagnosis, the principal and secondary diagnoses, as recorded upon discharge from the hospital.

That strategy minimizes provider burden. We would make little use of ADL-IDL information, using that to augment diagnosis information only if it and as needed --

MR. HACKBARTH: Excuse me. This is important information, but this probably isn't the best way to convey it. So I think it would be more effective if you could share your ideas with the staff and then we can consider it at an appropriate time. This is a problem we're not going to solve today but it's still one we're interested in. So by all means, share your information.

MR. VERTRASE: I'll do that. Thank you.

MR. HACKBARTH: We've got to adjourn right now. We reconvene at 1:15.

[Whereupon, at 12:32 p.m., the meeting recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:22 p.m.]

MR. HACKBARTH: The next item on our agenda is a continuation of assessing payment adequacy. The focus of our next session is hospitals, both inpatient and outpatient. Jesse, you're going to do the intro on this; is that right?

MR. KERNS: I'll be discussing the first step in our updating process for hospital services, assessing the adequacy of current payments. And then Jack and Chantal will address the second step, allowing for cost increases in the coming year, separating for inpatient and outpatient services.

The first step in this process is to determine whether the hospital cost base is appropriate. The second step is to assess the relationship of Medicare payments relative to appropriate costs. This will allow is to do two things, first assess whether the overall level of payments to hospitals is adequate and second, to then consider the

distribution of payments among hospitals. Our approach is to consider Medicare payments to the whole hospital for all hospital services purchased by Medicare.

In addressing the appropriateness of the cost base, we first considered the long term trends that established the hospital cost base in the 1990s. We know that cost growth was modest in the '90s. The biggest reason for this was large declines in Medicare length of stay. For three years in the mid-1990s, cost per case growth was actually negative.

Other factors that kept cost growth down were revenue pressure from private payers and slow wage growth for hospital workers. Based on these factors we concluded that the hospital cost base established in the 1990s was appropriate.

In recent years, we observed that hospital cost growth has increased, especially in 2001. We attribute this to smaller declines in length of stay as well as increased

hospital wage growth due to a tighter labor market as well as a nursing shortage. Because of these factors, the recent higher cost growth for hospitals does not appear excessive. This leads us to conclude the current hospital cost base is appropriate.

So we now turn our attention to the relationship between payments and cost. First, we'll consider broad indicators of payment adequacy for hospitals. This includes what investors think about the hospital market, hospital volume, closures and beneficiary access to care. We'll then review other payers payments to hospitals and the hospital total margin. After those subjects, we'll look at Medicare payments and Medicare costs. For this we consider the inpatient margin and the overall Medicare margin.

We'll look at each of these measures in several ways. For 1999 and projected to 2002 with and without DSH and IME payments above our estimate of Medicare's share of the added cost of teaching.

So first, what do investors think about the hospital market? Non-profit hospitals typically raise capital by issuing municipal bonds. There has been a lot of focus in recent years on the relatively large number of hospital rating downgrades, but we feel this has overstated the actual picture.

Despite these downgrades, over 90 percent of rated hospitals and health systems are rated investment grade right now. We note, though, that some hospitals are not rated and there could be some selection bias among hospitals.

One last point on the bond ratings, investment houses report that many downgrades in 2001 were due to increased borrowing by hospitals to fund capital projects, unlike earlier years when poor financial performance drove the downgrades.

Meanwhile, on for-profit hospitals, the value of the for-profit hospital stocks, capital-weighted, increased

over 170 percent from 1999 to 2001, while the S&P Index fell 19 percent. It does appear that investors also have a favorable view of for-profit hospitals.

Now we'll consider some macro level indicators of hospital financial performance, volume, entry and exit, and beneficiary access to care. Total volume from all payers has increased, especially in recent years, in terms of total admissions, total days, and outpatient visits. There was a net loss of 340 hospitals from 1990 to 1999, about 6.5 percent of all hospitals. It included 440 closures, of which about 40 percent were rural, and 100 openings or re-openings.

The OIG studied these closings and determined that closed hospitals were small, had low volume, and these closures did not affect Medicare beneficiary access to care. We also note that in some rural areas, access has been created by the critical access hospital program opening or re-opening hospitals in some communities. Despite these

closures, it appears there's still enough hospitals and there is excess capacity in the market. Average occupancy in 1999 was 54 percent.

Next we consider what happened with other payers. Medicare, Medicaid and private payers constitute about 90 percent of payments for hospital services. Last year, when we discussed these analyses, we noted that in 1998 and 1999 both the Medicare and private payer payment-to-cost ratio fell, breaking a long-standing inverse relationship that came to be known as cost shifting.

In 2000, however, the private payer payment-to-cost ratio increased slightly, about 0.2 of a percent. This is more pronounced for urban hospitals, where it increased a full percentage point, indicating that urban hospitals have begun to negotiate better payments from managed care. At the same time, the private payer payment-to-cost ratio for rural hospitals fell 2 percentage points.

Now we'll consider the total margin, which

includes all revenues and costs to hospitals, including operating and non-operating revenue. The margin for 1999 is a bit of an improvement from the 2.7 percent estimate we presented to you last year. This resulted from adding in data for hospitals with late reporting periods, giving an early indication that 2000 would be a better year. About 37 percent of hospitals had negative total margins in 1999.

While we do not have Medicare cost report data to determine hospitals total margins beyond 1999, we do have a quarterly survey of hospitals that provides a glimpse of hospital financial performance in both 2000 and 2001.

MR. DEBUSK: One point there. It shows 3.6 and you said 2.7. You told us 5.4 last year.

MR. KERNS: That was our preliminary estimate for 2000 based on some quarters of the NHIS. The margin for 1999 from the cost reports was 2.7. And this is good because we're going to update you on the NHIS numbers, for 2000 and 2001. Here they are.

Along with CMS, we fund a quarterly survey of about 500 hospitals. It's weighted to create a representative national sample. In 2000, the full year showed a 4.7 percent margin. And through the first three quarters of 2001, we see a total margin of 4.5 percent.

Because hospital total margins are typically lower in the last quarter of the fiscal year compared with the annual margin, this margin is probably overstated for 2001. I seasonally adjusted the margin and it corresponds to about 4.0 percent.

DR. ROWE: Jesse, this is all payers and all services?

MR. KERNS: Yes, sir.

DR. ROWE: Inpatient, outpatient, everybody?

MR. KERNS: Yes, private, public, this is the total margin, including non-operating revenue. So these findings suggest that the recent poor financial performance of hospitals -- yes, sir?

MR. MULLER: All costs, Jesse?

MR. KERNS: Yes, sir

MR. MULLER: Not just Medicare?

MR. KERNS: No, sir. This is all costs, all sources of revenue, total margin.

So this does suggest that the poor financial performance had perhaps reached its low point in 1999. On balance, the broad indicators of payment adequacy that we just reviewed do not appear to provide evidence of inadequate revenues to hospitals.

So having established this, we now turn our attention to Medicare.

This chart shows margins for each service component and the overall Medicare margin for 1996 through 1999. As in previous years, inpatient payments kept the overall margin positive in 1999, despite negative margins for all of the components. The overall Medicare margin did fall significantly from 1997 to 1999. However, when we

discuss payment adequacy, the Commission should consider the absolute level of payments in the system relative to the appropriate cost base, not the change in margin from earlier years.

Now we're going to look at inpatient and the overall margin projected out to 2002. In this chart, we present the inpatient margin for 2002 in two ways: with all payments and excluding DSH payments and the portion of IME payments that are above Medicare's share of teaching costs. MedPAC has determined that current IME payments to hospitals are about twice the level of Medicare's share of the added costs of teaching.

The margin with DSH and IME payments is a measure of the total dollars in the payment system. The other gives us an indication of how core Medicare payments relate to the cost of treating Medicare patients. In projecting margins for 2002, we reflect the effects of a payment policy change that will actually occur in 2003. That is the reduction in

the IME adjustment from 6.5 to 5.5 percent. We include this payment change to provide a more complete picture of how hospitals will fare in 2003.

We estimate that the inpatient margin in '02, after accounting for these reduced payments, will be 10.8 percent. By next month it will probably be higher by about 0.1 of a point. We have not yet been able to remove about 200 of the 500 hospitals that have converted to critical access hospital status in the last two years. Without DSH and above cost IME payments, the inpatient margin in 2002 would be 3.1 percent.

The most interesting point to note on this graph, though, is the margin for other urban and rural hospitals in 2002 without DSH and some of the IME payments. Most observers believe that rural hospitals were the worst off, but we can see that the level of their core Medicare payments, they have essentially the same margin as hospitals in other urban areas. But the margin for large urban

hospitals remains substantially higher.

This next slide shows the overall Medicare margin for 1999 and 2002. We estimate the overall Medicare margin in 2002 will be 3.8 percent. But it will be quite a bit different depending on where a given hospital is located. There is a nine percentage point difference between the margin for large urban hospitals and rural hospitals. This is narrowed from the 11 point gap in 1999 but still substantial.

We estimate that about 45 percent of hospitals in 2002 will have a negative overall Medicare margin. But this figure, as well, will be marginally lower because of the continued rapid growth of the CAH program and also because increased DSH payments to rural hospitals under BIPA will help a class of hospitals with much lower Medicare margins.

When we net out DSH and the above cost IME payments, the overall margin at the national level falls to negative 2.2 percent. A gap of almost four percentage

points remains between large urban and all other hospitals. On this measure, rural hospitals are the worst off by about 0.6 percent.

I remind you that the margins net of above cost IME and DSH are not the margin hospitals actually yield from Medicare. Billions of dollars are paid every year from the Medicare trust fund for both DSH and IME, and the Medicare margin, including these payments, is the appropriate measure of Medicare payment adequacy. It represents the amount of money in the system, which is what we set out to assess. However, these payments do lead directly to substantial disparity among hospitals and it could be characterized as an inequity.

Which brings us to the end of my presentation on payment adequacy, except for one last step, and that is to determine whether the amount of money in the system for Medicare payments to hospitals is about right.

MS. BURKE: Can I ask a question?

MR. HACKBARTH: Why don't you finish the sentence that you're on.

MR. KERNS: It just means that the Commission has to come to one of three conclusions, but implicit in this decision is the appropriate range of payment adequacy. You may not feel comfortable with delineating the range clearly. I tried to show this on the picture, the edges of each band might be gray and fold together.

Our best estimate of the overall margin, as I said, is 3.8 percent. If this is within the band of payment adequacy, we would not make any adjustments based alone on payment adequacy. But if, for example, the entire range of payment adequacy falls lower than 3.8 percent, say 0 percent to 2 percent or 0 percent to 3 percent, then you'd want to conclude that payments are too high and implement a negative adjustment. If on the other hand, the range of payment adequacy is entirely above 3.8 percent, say 5 percent to 8 percent, you'd want to conclude that payments are too low

and implement a positive adjustment. For the lowest edge of payment adequacy to be above four seems unlikely, but it is one of the choices available to you.

Regardless of what you conclude, you can also make distributional changes and implement them through the update. Jack will discuss the possible options on this subject next. For now, you just need to decide whether payments as a whole in 2002 are adequate.

MR. HACKBARTH: Murray, how is it most efficient for us to proceed? Should we pause now and discuss the material on payment adequacy?

DR. ROSS: Yes. If I can just change one verb there from decide to discuss payment adequacy, and you don't need to obviously not draw any final conclusions today. But to give us a sense of where you're coming out, to guide the update discussion that's going to follow with Jack and Chantal, and for next month.

MS. BURKE: Mine was just a question of

clarification. You referenced gross inequities as a result of the IME. I wondered what you were referring to, inequitable to whom?

MR. KERNS: If you look at major teaching hospitals or hospitals in large urban areas, and because it's revenue weighted that does tend to represent mostly major teaching hospitals. You have very high overall Medicare margins. And in rural areas, and other urban areas, when you net out the IME and DSH, they're quite a bit lower. We've already established that through the IME adjustment we're paying about twice the Medicare share of the cost of teaching.

The first question is as a whole 4 percent, is that adequate? But then the second would be in the distribution you have a nine point gap between one class of hospitals, large urban, and other hospitals, rural.

MS. BURKE: Both of whom have the same level of teaching that occur in them?

MR. KERNS: Not in the least. Large urban hospitals have much more of the teaching and most of the IME adjustment.

MS. BURKE: So I was wondering the reference to the term inequitable. If in fact most of the teaching occurs in those institutions, what is inequitable about them getting a larger percentage of the teaching funds?

MR. KERNS: I did say it's definitely a disparity and it could be characterized as an inequity.

DR. WAKEFIELD: But it's a subsidy piece that's inequitable. It's not the costs associated with teaching, it's the additional subsidy.

MR. KERNS: It's the subsidy above and beyond the cost of teaching.

DR. WAKEFIELD: Which is a very significant --

MR. KERNS: Twice.

DR. WAKEFIELD: Yes, so there is a big disparity I'd say, if you look just at the subsidy that goes into,

through IME and the teaching hospitals, for which there is no equivalent in rural hospitals, for example.

MR. KERNS: So you would characterize it as an inequity.

DR. WAKEFIELD: Yes, I would.

MS. BURKE: I might argue that point.

DR. ROWE: I wasn't going to comment on that point, but I guess my view of it is that you may reference that payment as twice what MedPAC has calculated it to be, and I don't know about whether the Commission has decided this, but I think Joe Newhouse decided that those payments were really for patient care costs, not for teaching anyway. So that's probably not...

DR. NEWHOUSE: But not the subsidy part.

DR. ROWE: No. And we had a separate discussion that there was a subsidy.

But I wanted to ask two questions, Jesse. One is I wanted to reconcile or relate page nine to page 12 here,

because we go from trend in total hospital margin to overall Medicare margin. You broke down the overall Medicare margins by urban, large and other, and rural. But you didn't break down the trend in total hospital margin.

I just wondered how that would look. The rurals, which appear to be disadvantaged relative to the large urbans, as you pointed out, with respect to either all payments or all payments without the DSH and IME with respect to overall Medicare. We have here had discussions in the past about the fact that Medicare doesn't negotiate with these rurals, but all the other payers do. And therefore, there's often a compensatory payment in that negotiation because they're sole community hospitals, they need to be in the network, et cetera, et cetera. That's not to say marketplace always.

So it would be interesting to have that comparison.

MR. KERNS: I'd be happy to walk you through a

brief piece on that. You may recall from last year when we were doing our rural study I did break out margins by urban and rural. Rural total margins do tend to be a good bit higher and they never really had the fall off in '97, '98 and '99 that you saw for urban hospitals. They are, best estimate in my memory, around 5 percent still. And they never really did fall off.

And what you touched on, the private payer payment-to-cost ratio, also expresses that. Rural hospitals have been able to yield well over 130 percent of costs on their private payer payments for the last 10, 11 years.

DR. ROWE: So my point being that as we get to the assessment of the adequacy, inadequacy or neutrality of the payments, if we get to a subset of hospitals that might be triggered by page 12, I just want us to understand the overall margin.

The second point relates to page 13 and the 3.8 percent and the interesting comments that you made and that

Jack referenced and that is in the material with respect to access to capital. I'd say a few things.

One, based on my experience, there is a selection bias here. You're right in saying that if you want to float bonds you have to get a rating. But the fact is that you go and you find out what your rating will be. And if it is not good enough to support floating the bonds, then you don't get the rating. Because it doesn't do you any good to have a bad rating, if you don't need a rating at all. And therefore, all of the hospitals that would not get ratings that were adequate don't get rated.

Secondly, is investment grade rating, which you referenced Standard & Poors, so that's BBB, I think. That is often not adequate to float bonds. In many states the authorities, which are established to underwrite the issuance of bonds for not-for-profit institutions, which would include hospitals and many other places, require ratings that are substantially above investment grade.

In fact, there have been many hospitals, I believe, that have been downgraded from a rating that would support a bond offering to a BBB, which is still investment grade. But they do not have access to the capital markets.

The last point I would make about this, or two more. One is that I think this is a rapidly changing -- this is another area in which the latency of our data are a problem, because I think with the recent changes that have occurred in the economy and certainly in certain areas like California and New York. New York's hospitals are staggering, as a group, New York City's anyway.

And that there may be many more downgrades than have been reflected in the May data, that conversation you had with Standard & Poors. I would ask you to just refresh that. That may not be the case.

MR. KERNS: These conversations with both Standard & Poors and Moody's were this week. These are to date.

DR. ROWE: Okay, because I thought it said May in

the material I had.

The last question I would have, and I don't know if it's for you or for some of the economists we have on the Commission or what, but did you have in your discussions with S&P this week -- let's take advantage of the fact that it's this week. Did you ask them what percent overall margin would be appropriate for a hospital to maintain a rating that would be -- all other things being equal -- adequate for them to access the capital market?

In other words, in your box here, market factors, one of them is access to capital. So my question is what kind of performance do these people who you're referencing and talking about judge to be appropriate -- all other things being equal, which they never are -- for them to consider that hospital to be eligible for consideration for a rating that would support access to the current capital market?

MR. KERNS: The simplest answer or the question

there is it seems like you'd be referencing a total margin and not a Medicare margin. You've already pointed out the disparity between hospitals with strong Medicare margins and total margins. There's an inverse relationship there, as well. Rural hospitals, strong total --

DR. ROWE: I don't think that they care whether it's Medicare or what. Just total margin, what would be the number?

MR. KERNS: The short answer is, no, I did not ask that question. The other thing is I don't think they'd just be looking at total margin. They're looking at a variety of factors. But it was typified that for the muni bond market for hospitals, by both people I talked to at the two major houses, that it's strong right now and that there is access to capital.

I also would point out that investment grade or higher. It's not that 90 percent are rated BBB. It's that 90 percent are rated BBB or higher.

And third on that, it's hospitals or health systems. So they may have 90 percent of hospitals or health systems rated there, but when you have a 200 or 300 hospital system that has AAA, you actually are probably going to look at a much greater percentage of hospitals that have a higher rating than hospitals or health systems. So that 90 percent itself is sort of an understatement of the total volume of hospitals that have decent ratings.

DR. ROWE: I think for the purposes of -- I think you separate profits and not-for-profits. And the not-for-profits have some systems that go together as an obligated group for the purposes of underwriting bonds, but they don't have 200 to 300 hospitals usually. So I was really concerned about separating those two.

But that's very helpful. Thank you, Jesse.

MR. HACKBARTH: David, did you have a comment on this particular --

MR. SMITH: Yes, I did. Jesse just got to some of

it. Jack, I wondered, there's always a little bit of confusion when someone talks about access to capital markets. With a BBB rating, you've got access to markets but it may be access to markets at a price you don't want. But I think we ought to be clear that there isn't a bright line here at BBB or above which is a go/no-go. There are price consequences and feasibility consequences, but a hospital with a BBB rating has got access to capital markets that may not choose to exercise -- it may not make sense to exercise it, but doesn't not have it. Isn't that right?

DR. ROWE: Yes and no. I think it is. It depends on where and what kinds of capital and how much. You can get $20 million chunks but you can't get big things, et cetera.

One of the problems, of course, David, as you know, is that insurance for hospitals basically disappeared after the Allegheny bankruptcy. So that's made it a somewhat tighter marketplace, as well as the recent changes.

I think that's right. I think this is a spectrum of availability to access capital markets.

I'm delighted it's on the radar screen because a couple of years ago it wasn't as one of the considerations. That's all. I just wanted it in one of the considerations.

MR. SMITH: I think it's important to underscore something Jesse said, which is that margin is an issue for the bond market. It's not the only issue. Reserves would be an issue.

DR. ROWE: Right, philanthropy, debt, other debt, et cetera.

MR. SMITH: Ongoing capital budget requirements are an issue. So looking at the margin, particularly an annual margin, is probably a pretty small piece of the puzzle that a rater is going to look at.

MR. HACKBARTH: Before we get too far from it, it wanted to just quickly go back to the point about looking at total margins, all payer margins. I think that's important

information that we ought to have and take a look at.

I do think we need to be systematic and consistent in our approach about how we use it, though. I don't think we can say well, it's relevant when we look at hospitals, but it's not relevant when we look at SNFs. So we've got to come to grips with that question.

MR. MULLER: Several points. Just one more kind of factual point on looking at the ratings. As Jack pointed out, up to about a year or so ago hospitals could get insurance to go to the bond market. And secondly, many states have state guarantee agencies.

So I just wanted to second the point, there's a lot of selection bias in looking at who gets ratings, because if you can't get a rating, then in fact, in many states there are state agencies and so forth that will guarantee it. So you can go. It's just important.

I'd be very cautious about extrapolating too much from the fact that these hospitals get these investment

ratings, because the ones who can't figure out some way to borrow.

MR. KERNS: A comment on that. MBIA is the largest underwriter of bond insurance, and as I understand it it was up until about a year ago that they weren't really taking on new business, but that they are indeed taking on new business. I've spoken with people there a couple of times, as well.

MR. MULLER: I'm just saying if you do look at a period of years, certainly the '90s and so forth, until the Allegheny collapse, people would go to the MBIA and so forth, and they would also go to the state agencies in New York, Illinois, and others.

I want to come back to the factual point that I asked before. On page 12, the question that I asked before about all costs. Do we again have all costs on this calculation? On the middle column, the all payments? I

know we had some debate about Medicare allowable costs and all costs.

MR. KERNS: Those are all Medicare-allowable costs. The non-allowables are netted out. The non-allowables make the big difference on the inpatient side.

MR. MULLER: Roughly what percentage do you think would be non-allowable, just as a percentage?

MR. KERNS: Best of our estimate, maybe about 3 percent to 4 percent.

MR. ASHBY: We really don't know. We're going to do a study on that.

MR. MULLER: If it's 3 percent or 4 percent, that could take a lot of the AAA away.

MR. KERNS: We are going to do a systematic review of the schedule A8 on the cost report, where those non-allowables are netted out. That's going to take some time. That's something that I'm going to work on this spring.

MR. MULLER: I'm just making the point that if it

is 3 percent to 4 percent, and I understand Jack is saying that.

MR. KERNS: I would have a hard time standing behind any number.

MR. MULLER: But it could, on average, take the whole margin away?

MR. ASHBY: I would be really reluctant to assume it's anywhere near that large. And that's probably the reason why we're finally going to measure that. I'm not convinced that it's that large, actually, but none of us really know.

MR. MULLER: No, I'm just repeating what you told me. I didn't make my own estimate.

MR. KERNS: That's at a maximum. There are a variety of things that could bring that down, including that those things are sometimes paid elsewhere by Medicare, and then netted into the costs that are ascribed to inpatient.

MR. MULLER: The other point I would make is on

the use of terms. Obviously a term like inequity is perceived by many people as a different term in differential, which may be a little less neutral.

When things are put into policy, and certainly DSH, for example, has been put into a policy for quite a while and IME as well, those are statements of purpose and mission that government is trying to secure. They may debate about whether they should or not, but they're in there. Whether one then wants to call the consequence of that as inequitable, I think, is probably a little bit more a value-laden term than I would prefer.

Certainly, looking at the distributions, I think, is very appropriate for us to look at. I think part of the concern we had, whether it's in the SNF discussion or in this discussion here to come, is these averages mask an awful lot of variation. I think one of the things we have to get at in the whole accuracy discussion is how much variation do we think is appropriate in these kinds of

programs and how much adjustment do we want to make.

Let me ask one more question, which probably is more of Murray or everybody. In understanding the adequacy diagram that we had earlier, looking at all the factors in adequacy -- I don't want to recite them all again -- and then also looking at the update discussion. If we look at these questions of distribution, whether it's on SNFs or hospitals and so forth, my sense is if we're going to have this newer model of adequacy and update, then to also have redistributional questions and say that's part of the update discussion causes me to think that we're undoing the model you just created.

If you want to get into redistribution questions that should be, in my mind, a different question and the update question. So if you have adequacy and you have concerns about distribution, you shouldn't therefore -- maybe it was just a slip of a tongue that said well, we'll take care of that in the update. But I think we should, if

we want to get into distribution questions, not call that an update question.

DR. ROSS: Conceptually, obviously you want to distinguish, I think, distributional questions from payment adequacy, which is how much money in the pool. But given the fact that no one, whether it's hospital, SNF, or whatever, is average, it's almost impossible not to think a little bit about distribution as you're looking at overall adequacy.

Overall adequacy is total trust fund disbursements and costs of caring for Medicare beneficiaries, at some level. But you can't avoid, at the same time, if you see large differences, asking whether those are appropriate.

MR. MULLER: No, and I'm not saying we should avoid it. But I'm saying, however, to immediately put that right back into an update discussion kind of takes away the model right in the beginning.

DR. REISCHAUER: But some of these payment systems

have different bases for urban and rural. So it is relevant to ask is the urban base adequate? Is the rural base adequate?

MR. ASHBY: The primary reason we bring it up in this context is because the update gives a vehicle for instituting changes. I mean, we could address distribution issues separately and frequently do. But if we thought it was appropriate to make a distributional change, then taking it on to the update, as it were, is a way to get it done. But it's really separate from an update issue, per se.

MR. MULLER: If in fact one wants to think of the update as a more technical estimate of how costs are changing, rather than a kind of fudge factor into which you throw all considerations, whether it's considerations of Congress as to how much they are willing to afford, whether it's considerations of other kinds of things one wants to rectify.

I think part of the virtue of the new construct

you've put forth is, in fact, to try to separate these things. I'm not saying that people then ultimately don't make some judgments here and there about what they're willing to do, no matter what the construct is. But I think it's appropriate, if we're going to go with this new construct, to honor the construct at least for a while.

MR. ASHBY: Yes, but by keeping them separate, I think that we can still honor it. If we look at payment adequacy and we decide payments are adequate, then the adjustment is zero. If we look at the cost increase to the next year and we decide market basket is the right figure, then market basket is it. And then thirdly, if there were an adjustment to the base rate up or down for some group of hospitals that we thought was appropriate, we would tack that on to the end.

And by keeping the three pieces separate and on paper we're sort of accountable for what we're doing. Does that make sense?

MR. MULLER: I think that's the right way to think about it.

DR. STOWERS: I had a question about a little different kind of variability. We have an overall of 3.8 percent. What's the variability in those that are above and below a positive margin? For example, what percentage of the total are going to be below zero, as far as that?

MR. KERNS: In 2002, 45 percent of hospitals would have a negative total margin. I'm sorry, negative overall Medicare.

DR. ROWE: That's a Medicare margin.

MR. KERNS: Negative overall Medicare.

DR. STOWERS: I'm talking total margin.

MR. KERNS: Oh, negative total margin in 2002? I don't have a projection of that. I know that it was about 37 percent, 36 percent in 1999.

DR. STOWERS: But I think that distribution, when we look at what the impact is going to be across the

country, is important. And so somehow in there I think that may look -- I know we have to look at it in a global way, but when you look at impact in the field, and we look at how we're distributing the funds, I think that's still important.

The second point that I had is there's a lot of large urban hospitals that do not receive a significant amount of IME funding. I would like to see a breakout of those margins for larger urban hospitals with a significant amount of graduate medical education and those without to really know how much of those margins are due to the fact that they're a large urban hospitals or to the fact that they're receiving the IME uncompensated care and low income and all the other -- so I think that breakout, I think we may be grouping too much together in that large urban category.

MR. HACKBARTH: Can I pick up on Ray's point there? When I look at page 12 in the table, it's striking

to me how important IME and DSH are in determining the winners and losers under this system. It's real easy for us to fall into the habit of saying well, everybody who's in the urban category is getting these payments to the same degree, which I don't think to be true. I don't think that's the case.

And so within some of these categories then, our old tables look okay. This category looks like it's got a high margin. In fact, there can be a great disparity, depending on how much of the IME and DSH money they get.

MR. ASHBY: Let me respond to that in a little different way. We were actually asked this year to do further analysis on the factors that determine those with high and low margins, the winners and losers if you will. We looked at the numbers that we put up today as sort of like the first installment on that. Because when you look at just the limited groups that we've looked at, it becomes exceedingly obvious, as you say, that the DSH and IME play a

major role in determining the hospitals at the tails.

But that was the first installment. We do intend, in the next cycle, to do a more involved analysis on what are the factors, what is the distribution and what are the factors that govern it. I think we will begin to shed some light on that.

DR. ROWE: If we're going to get -- it sounds like we're having discussion, as we point out, rather than making a decision, to get some additional information, I think that's useful. Some of these analyses about the distribution would be very helpful in terms of the subsets and the ones that are underwater.

I think the other thing that if we could get just one page on I think would be kind of interesting is that despite Dave Smith's experience in city government and mine in hospital management, neither of us would get hired by Moody's or S&P. It would be interesting to get somebody from one of these places to actually give us a statement

with respect to the not-for-profit hospitals and the relative importance of different characteristics. And then we can sort of settle it, since it is on your list of market factors. And get a statement from them about their assessment of what it's like right now, what the issues are, and how important one thing is versus another.

MR. ASHBY: As managing this process, I do have to ask how much we're thinking about this. But perhaps we could do some limited distributions. As you say, we could look at what the percentiles are within these broad groups that we've looked at. I think if we did that before subtracting out the above cost IME and DSH, and then after you'd find that the distribution is a lot less afterwards. But I think that basic level of analysis we probably could do for next time.

DR. ROWE: For overall as well as Medicare.

MR. ASHBY: Right.

DR. ROWE: And we could get a letter from one of

these rating agencies in a week.

DR. STOWERS: I think what I'd like to see on the GME thing, our experience is the large urban hospitals that do not have the graduate medical education are actually doing a lot better than those with.

MR. ASHBY: Medicare or overall?

DR. STOWERS: Overall. So I would be interested to see how that works out on the distribution.

DR. WAKEFIELD: Jesse, we talked a little bit about the issue of access to capital and the importance of that. I'm thinking about access to capital now in the discussion that you provide related to -- well, in the text on the bottom of page five and six.

I'm trying to think about the relevance of this discussion to rural hospitals, for example. And so when I look at access to capital to improve equipment and physical plant and it's okay, but what's the relevance of that indicator, i.e., bond ratings for example, for access to

capital for rural hospitals since about 45 or so percent of them are publicly owned by counties or towns? So what's the relevance of something like a bond rating when we think about access to capital for this big category of rural hospitals.

And also, what's the relevance of discussion -- and so I'm trying to think about what's another way of getting at that issue of access to capital? Because clearly it's important for small rural hospitals, as well.

The other part of this, the indicator of their stock price, as well. In terms of stock prices, only about 8 percent of rural hospitals are for-profit, and I'm not sure how many of those are going to show up on any sort of stock index. But only 8 percent are for-profit, I think, of rural hospitals.

So my question is is there anything else we could be looking at or thinking about to try and get a handle on access to capital if this is somewhat less relevant to those

hospitals? Anything else you can think of?

MR. KERNS: I'm open to ideas.

MR. MULLER: Just a quick follow-on to Mary's question, since a lot of the safety net hospitals in the country are, in fact, governmentally owned, when they borrow for their capital needs it's not done as a hospital. It's done as a governmental agency.

So you can look at those numbers of borrowings for hospital type, and kind of look at the trends, whether it's drying up and so forth, by the New York Cites and Chicagos and LAs of the world, and so forth. You can get some sense of whether that's going up or down in terms of their borrowings.

MR. HACKBARTH: I look at page 12 at the question that I keep coming back to is is the system healthy? Is it functioning properly when the only way to have a positive margin -- I may be overstating this a bit, but allow me to do that -- is if you get payments that are by design

unrelated to cost, namely IME and DSH?

If you're just under the basic system, you're going to lose money. That doesn't sound like a very healthy situation to me.

MR. MULLER: You really want to go that far and say they're unrelated to costs?

MR. HACKBARTH: If we're talking about the half of IME -- unrelated to the Medicare costs. Yes. So if we're talking about the so-called subsidy piece of IME, it's beyond what the formula shows. And then the DSH, by definition, is for non-Medicare patients. So we've got a basic system where you don't do very well unless you get these supplemental payments unrelated to your Medicare costs. That's what the table says to me.

MR. MULLER: There's some part of IME that obviously is related to costs. There's DME that's related to costs.

MR. HACKBARTH: This only has to do with the half

of IME unrelated to costs.

DR. NEWHOUSE: I want to try to frame the debate as I was hearing it. First of all, on the distribution side, there's at least two policy issues running through here. One was alluded to by Bob, the large urban differential of one or one plus percent relative to -- by large urban here is meant, I believe, metropolitan of 1 million or more population, if I remember right.

So relative to everybody else, even holding things equal, they get another percent or so.

MR. KERNS: 1.6.

DR. NEWHOUSE: 1.6; thank you. However, as I recall, that does come out of the regression. So in a sense, there's just basically some higher costs there that we can't otherwise explain with what we've got in the --

MR. ASHBY: No, no. That's not the case, actually. As an advance on what I was just going to say, I'll just go ahead and say it now. The multivariate

findings were that there is, in fact, no difference between the hospitals in major urban areas and other urban areas. In fact, the other urban areas is actually a tad higher.

There is, though, a difference between the costs in urban areas in general and the costs in rural areas. The rurals are lower. That leaves you wondering whether they're lower because they didn't have the resources to spend. But be that as it may, there is a difference between urban and rural. There is not a difference between large urban and other urban.

DR. NEWHOUSE: Thanks. So that's one policy issue on the distribution side. The other one is the one that we've just been mostly talking about, which is the roughly half of IME that's above so-called empirical level or the subsidy. I just wanted to step back and try to put both of those in a somewhat larger picture that also actually goes to the point about the distribution of hospitals and what percent they're in, have negative total margins, and so on.

We have set up a system and have lived with it for lo these many years now that attempts to be a national system that has some adjusters in it for local conditions but those are going to inevitably be imperfect. In particular, the system really ignores local market conditions.

So this comes up in the discussion where I think Jack started out to lead with the total margin and the rurals. Private plans can exploit the competition to a greater degree in the urban areas than they can in the rural areas. Put it another way, rurals tend to have more market power. It shows up in the total margin.

The question is should Medicare take cognizance of that, whereas it doesn't now because it basically has a uniform system. As I said, it doesn't really attempt to measure competition in the local market. One could regard the two policy things that we're dealing with, the urban differential and the IME subsidy, as very crude corrections

for that.

By the way, I should say I personally would get rid of the urban differential and I would get rid of the subsidy in IME. But in trying to think about a framework for how to think about these issues, I think one of the relevant things is should Medicare, in some way, take account of local market conditions.

The other, and it's quite relevant, I think, for the negative margins, is what does Medicare do about hospital circumstances that are heterogenous other than the local market conditions? Different unmeasured case mix, different management capabilities, different degrees of philanthropy, different degrees of support from local governments or state governments.

Hospitals come in all sizes, shapes and flavors. Medicare essentially tries to strike a rate that falls somewhere in a quite diverse distribution. If it goes toward the high end of the rate and lowers the percent with

negative margins, it's going to essentially give windfalls to the people that are in the better off circumstances and conversely, as it pushes tighter, it will disadvantage the people at the high end. It seems to me that's just a fundamental problem here that we have.

But what I think we have to come to grips with is that we have sort of a one size fits all system in the PPS and inevitably there's going to be things that stick out that are going to want to be sanded down. It's a question of how far we go along that path.

DR. REISCHAUER: With respect to whether Medicare should take advantage of differential market power in different areas, I would suggest that the answer is a clear no because to the extent it did it would raise the cost of insurance in those areas, private insurance, and increase maybe the number of people uninsured.

It has an ability and an obligation, I think, to exercise its average market power in the nation --

DR. NEWHOUSE: As I said, given where I came out on the things, I would not take advantage of it, either.

DR. ROWE: Can I ask a question about that, Professor Reischauer? Why is it if the previous observation about the reciprocal nature of the Medicare payments and the other commercial payments holds, then if we paid more in rural areas for Medicare because the Medicare margin is down, one might expect that that would reduce the payments from the non-Medicare payers and the overall cost of insurance in that market would not go up.

DR. NEWHOUSE: That should hold in competitive markets, that reciprocal thing. Once you have monopoly, then there's no reason why the hospital shouldn't exploit its market power.

DR. ROWE: I don't know what the experience has been with respect to these hospitals.

MR. SMITH: But, Jack, that does assume quite improbable behavior. Without any change in degree of market

power available, that prices in the private side are going to be reduced reciprocally to increases on the Medicare side. I can't imagine why that would happen.

DR. NEWHOUSE: That's the data.

MR. KERNS: Medicare improved as a payer in rural areas for the last eight to 10 years, and private payer payment-to-cost ratios didn't budget. Even as costs went up faster in rural areas.

MR. SMITH: That was my point.

DR. ROWE: So the point is that this reciprocity doesn't count there, or doesn't occur there?

MR. KERNS: It's correlated, there's no causality.

MR. MULLER: It's correlated with the weights.

MR. HACKBARTH: I'm a little confused in this exchange. It would be helpful to me, Bob, if you would restate your point one more time. Let me make sure I've got it.

DR. REISCHAUER: I'm not sure now that we're on

the same wavelength here. But I do think, and you're telling me the data doesn't show this, that if Medicare were a better payer in rural areas, Jack would be paying hospitals less in those areas because I think a lot of these hospitals are municipal county hospitals and that they are trying to cover total costs and not trying to maximize rent.

DR. ROWE: That was the point of my question. That's what I'm trying to clarify. That's what I thought he was saying.

DR. NEWHOUSE: I don't think we've seen those data on total margins.

MR. KERNS: You've seen rural total margins for 10 years. You've seen rural payment-to-cost ratios for private payer and for Medicare for the last 10 years. Medicare improves each year. Private payers do not fall a bit. 134 percent of costs for 10 years, from '90 to '99, even as Medicare improves, say six to eight points.

DR. NEWHOUSE: All right, that confirms what I

thought, which was that under competition that you will get this inverse relationship. And with market power, there's no reason to observe it.

MR. SMITH: I thought Jack was headed in a different direction. I'm struck by another sort of crude balancing. There is, and partly intentionally and partly as an artifact of two different payment policies. But the Medicare margin and its distribution as a result of IME and DSH payments does, in an important way, on a geographic basis compensate for the higher overall margin that's been sustained. We don't know how to deal with either of those phenomenon entirely through the Medicare payment system.

But we've got this sort of crude balancing mechanism. It's a subsidy in the urban areas who can't avail themselves of the same kind of market power that's available to rural hospitals. Medicare payments don't quite compensate for costs in rural areas. The inverse is true, particularly in large urban areas.

You never actually own up to having designed the system that way, but I'm not sure that the outcome is not better than if we tried to tinker with each of the sort of odd balancing items that have ended up here. I'd be very cautious about trying to make Medicare margins equivalent in these situations where very different market power is available to the institutions.

I think if you look at the total margin data, as modified by Jesse's observation that the rural/urban distinction is held, and then you look at the Medicare margin data, there is a crude reciprocity there that may be the outcome we'd want, and we couldn't get there if we tried to get there with precise Medicare payment policy.

MR. HACKBARTH: Are we saying that we want to do is have Medicare pay money to hospitals that lack market power? If they lack market power, it's because there are lots of other hospitals there to serve Medicare beneficiaries and lots of competition. I'm not sure that we

want to pay more to hospitals that lack market power.

I thought the more plausible argument is that these hospitals carry other burdens that the federal government needs to recognize.

MR. SMITH: No, that was precisely my point. But because they lack market power, they aren't able to compensate for those other burdens with tools other than public payment policy.

MR. HACKBARTH: But then that gets us back to the question I raised earlier. If in fact we start to say, in formulating Medicare payment policy we look not just at Medicare margins but total margins, where do we draw the line? Does that apply to every class of provider? You open that door a little bit and a whole lot of people will come in and say well, I qualify. My total margins are bad, pay me more.

MR. SMITH: Most of us weren't around -- Bob and Joe may be able to help. But clearly, DSH and IME have

their roots in precisely that observation. And folding them into Medicare was taking advantage of an available tool in order to do precisely what you just said, which is address the discrepancies in the ability of hospitals to maintain positive margins.

DR. NEWHOUSE: Actually DSH and IME, I would have said, differ on that score. That description applies to DSH and not to IME. IME was a recognition right from the outset that teaching hospitals had higher costs and something was going to have to be done about that in the system. The subsidy got built in because people were in a hurry to get the legislation through and that was kind of a crude approximation. The original way of dealing with it had some methodological flaws and they said well, we'll just double the empirical level. And we've been kind of working our way down from there.

MR. HACKBARTH: We need to move on to the next step in this analysis which is Jack talking to us about the

inpatient update.

MR. ASHBY: We actually had two remaining issues here on the inpatient side. One is the redistributional one we've already talked about a bit, and so I'll just kind of customize my comments there. The other is the adjustant for cost increases in the next year.

Taking on the cost increases for the next year first, this begins with our forecasted increase in the hospital market basket, which is 2.9 percent. I would just add by way of side commentary, that this is a brand new forecast that just came out in the last few days. The forecast has been reduced from the previous one, presumably reflecting national events and a downturn in the economy.

Other considerations that might go into this adjustment for the next year. First off, let me say that lacking any ability to really measure either the cost impact of technological advances or productivity change, we are basically planning to assume that the two offset each other.

I would comment that we have a tech pass-through payment on the inpatient side now. But by law, that is to be implemented budget neutral and so basically should not be a factor in considering overall payment level.

A different kind of issue, the cost of disaster preparedness is especially likely to be a major issue in the coming year, but we've gone into this with the assumption that any new federal monies will not be routed through Medicare, which is probably appropriate given that the goal is to protect the entire population. So again, we are not proposing to deal with this.

In theory there's a third issue that might come into play here, and that is that we might project per discharge cost increases to be below market basket because we expect further decline in the length of stay. The reason we might expect the further decline is that we have had declines 10 years in a row and our National Health Indicator Survey strongly suggests that we're going to have an 11th

year of decline in 2001.

But on the other hand, there is some evidence that the length of stay is stabilizing. That is, the annual reductions are getting smaller. And then we have to say, in fairness, that as with the technological changes, we have no real way of making a prediction of what's going to happen way out in 2003. So we were not proposing to go down this path either. We're putting it in the same class as the technological changes. They are sort of small factors that we really can't deal with very accurately in a prospective way.

So that leaves us with the market basket forecast as the best estimate of the increase in efficient providers costs. To get back to Ralph's comments of a few minutes ago, we would indeed apply that to all hospitals because the cost increases to the next year would be expected to be the same for all hospitals. By comparison, the current law is market basket minus 0.55 percent.

Now, turning to the redistributional issue, as Joe pointed out the base rate is 1.6 percent higher for hospitals in large urban areas. What we wanted to focus on here is -- this is the perfect place for use of our margins, having subtracted out DSH payments and the portion of IME above costs, because it is that level when we're looking at our core Medicare payments that are to relate to the cost of care that we see that the margin for hospitals in large urban areas remains about four percentage points higher.

So irregardless of what subsidy type monies the system has put out there to help these hospitals with their market conditions, they're four percentage points higher even before considering those various subsidies.

This isn't supported by the cost analysis, as we pointed out a minute ago. So we thought that there's a policy issue here. There is the possibility that we might want to, perhaps not in one swell swoop, but we might want to narrow the gap in the base rates by subtracting a small

increment from the update that would otherwise apply for large urban hospitals and adding a small increment for other urban and rural hospitals.

It happens by sheer coincidence that the two groups are weighted equally. So for example, if we were to have a plus 0.5 and a minus 0.5, it would be budget neutral naturally.

Ideally, we would probably want to continue to treat the other urban and the rural groups as a single group to avoid going from two to three base rates. If anything, we'd like to go in the other direction, towards one base rate with adjusters as appropriate. So that's a consideration to keep in mind.

Then, the difficult part is that obviously we should consider that a prospective change, in light of other changes that may affect the distribution of payments between these groups, and there are several potential of them. So it creates a rather complex picture.

If we could look at the chart, the first one of them is the reduction in the IME payment that's scheduled to go into effect in 2003. I want to remind everyone that that was taken into account in the modeling. So the 3.8 percentage that we saw is after that reduction. But we put it up here for information purposes because we thought that it might be considered relevant in a dynamic sense. You'd have to ask whether we would want to reduce the gap in the base rates in the same year as this IME reduction takes place. Because for some hospitals, they would have to absorb both simultaneously.

The second one you see there is the adjustment for occupational mix in the wage index. This will indeed, on average, reduce payments to hospitals in large urban areas and raise them form hospitals in rural areas. But this is only on average. And we don't really know now much.

An analysis we did some seven or eight years ago suggested the answer might be in the neighborhood of 2

percent of the bottom and the top. But that's old data only from one state. Basically, we don't know.

We're also not sure how this would play out in the middle group, the other urban areas. Most assuredly there will be some combination of increases and decreases, and I couldn't even conjecture where the average would fall. And then the big problem here is that this isn't going to happen until about 2005. So we have an issue that's somewhat analogous to our RUGs in SNF this morning. What do we do for the three or four year period before this takes place?

Critical access, we only mention it in the sense that, as Jesse mentioned, there are 200 hospitals that have gone critical access that are not yet reflected in our analysis. And so we would expect to see a further increase in payments for those rural -- the average that you saw for rural hospitals will rise by these 200 hospitals dropping out because most of them have negative margins.

Then lastly, and probably most problematical, is

our series of recommendations. This includes both the reform of the disproportionate share system that we published in March and our rural recommendations in June. This presents a very uncertain situation because virtually none of these, as everyone knows, has been enacted, although there has been Congressional interest in virtually all of them. We just simply haven't gotten there yet.

The DSH reform impact numbers that you see there, this is actually new analysis that we just finished up in the last couple of weeks. You'll see that done budget neutral, our proposal would significantly raise payments for rural hospitals with a small reduction for urban hospitals.

Our other recommendations, you see the numbers, but those are very basic. Depending on exactly how these are specified, the impact could be significantly greater. We really can't do an impact analysis yet, because some of these recommendations were in a very general form that would require further specification before we'd know what would

happen.

So these are the things that are all sort of in the back context as we consider the possibility of this adjustment to the base rates.

MR. HACKBARTH: Would it make sense, Jack, to bring Chantal up here to talk about the outpatient piece?

MR. ASHBY: It would, yes.

DR. WORZALA: Good afternoon. Now we're going to turn to the hospital outpatient update.

The law established the update for the outpatient PPS through 2002. And in the absence of additional legislation, in 2003 the Secretary will establish the update based on the hospital market basket index used for updating the inpatient PPS. However, no outpatient PPS process has been described in regulation to date.

The law does allow the Secretary to adjust the update in response to excess volume growth. MedPAC has recommended that the Secretary refrain from doing this and

has recommended an update approach that takes into consideration the factors affecting efficient providers costs. You've never heard that before, I'm sure.

As with the inpatient PPS, MedPAC will make an update recommendation that follows our conceptual approach outlined this morning. This is the first time that we will make an outpatient PPS update recommendation.

The first consideration in determining the outpatient update is any increment to be added or subtracted due to our conclusions regarding payment adequacy. As we just went through, payment adequacy was judged at the level of the hospital. And so we would have to think about allocation of a payment adequacy adjustment to the inpatient and outpatient payments.

One approach would be to treat them equally, with the same increase or decrease applied to both. For example, this is purely hypothetical, if we determine that hospital payments as a whole are 5 percent too low relative to costs,

we would add five percentage points to both the inpatient and outpatient updates.

Another approach, however, might be to make different adjustments in each sector. We would do this if we thought that payments relative to cost were more or less adequate for one sector versus the other. For example, we might think that the cost basis overstated for outpatient services and understated for inpatient care. And in fact, the limited information that we have, which comes from a study using 1991 resource cost data, does suggest that outpatient costs are overstated by as much as 15 to 20 percent with inpatient costs correspondingly understated. We would like some more recent data, but we don't have it.

If we adjust the margins to account for that difference in cost allocation, inpatient margins do still remain five to six percentage points higher than the outpatient margins. Just as a point of information, when thinking about allocations between the two sectors, the

inpatient payments are about five times larger than the outpatient payments.

Okay, so that's it on sort of follow up from payment adequacy. The next consideration in the update would be expected changes in costs for calendar 2003.

The latest market basket forecast is 3 percent, which is slightly higher than the market basket for the fiscal year 2003, which is 2.9.

The next update factor that we might want to consider on the outpatient side is cost changes due to technological advances. This is a little bit tricky on the outpatient side because the payment system does have two mechanisms in place already to pay for new technology. One of these mechanisms, the new technology APCs pays for a completely new service. So you have a completely new APC code.

It is not budget neutral, which means that the costs of this type of new technology are funded through the

base payment stream and do not therefore need to be taken into account in determining the update.

The other new technology payment mechanism, which are the pass-through payments for inputs to an outpatient service, is implemented in a budget neutral fashion and it's therefore analogous to the recalibration of relative weights among services. Therefore, we may want to consider the net increase in costs due to these new technologies after taking into account, of course, any technologies that decrease costs.

Of course, as a practical matter, and is the case on the inpatient side, we do not have a reliable measure of the net change in costs due to technological advances in outpatient services. So we may wish to follow the same logic as has been suggested before and assume that cost increases due to technological advances are offset by productivity gains.

As a further note on the outpatient side for the

year 2003, we do not anticipate any significant pro rata reductions for the pass-through payments because the volume of items that will be funded through the pass-throughs should decrease dramatically in comparison to 2002.

A final factor that might affect outpatient costs in 2003 is the continued roll out and implementation of a relatively new payment system. Hospitals have certainly experienced some cost increases due to information systems and improved coding that's been needed for the PPS. However, most of those costs should be absorbed before 2003.

In addition, experience from other new payment systems has shown that hospitals generally do constrain their costs in response to the uncertainty introduced by a new payment system.

So now I'll just turn the presentation back to Jack to present a summary of the discussion.

MR. ASHBY: We can put up this last overhead and I was only going to do about 10 seconds worth, and that is we

thought it might be useful to create this little framework -- it's actually a scoreboard, I guess, for the factors that we might work through in our decision.

The top line represents basic payment adequacy. If payments are adequate, zeros. But if payments are more or less adequate, we have a number on that top line. And it raises the second question, which is do you want that number to be the same on the inpatient and the outpatient side? Hence, the two lines.

Then vertically, on the inpatient line only, we have the question of possible upward adjustment for other urban and rural areas, downward adjustment for large urban areas. Then we go down to the next line, that has the two next to it. There's the adjustment for next year. That would be on the order of 2.9 percent. I guess it was three points for outpatient. And then the bottom is just the sum of the two across the board.

So that gives you an idea of what vehicles we

could use for our various decisions here.

MR. HACKBARTH: Jack, can I go back to page 15 and the discussion of eliminating, perhaps in steps, the urban/rural differential in the base rate?

MR. ASHBY: I'm sorry, I was scrambling for my paper.

MR. HACKBARTH: The urban/rural in the base rate. You say one of our options is to eliminate that or do so in steps?

MR. ASHBY: Yes.

MR. HACKBARTH: This was an issue we discussed when we did the rural report. It was not one of the options that we included in the recommendations we included in the final report. Could you just refresh my recollection as to why we didn't do it then? Has anything changed?

MR. ASHBY: We cast it in terms of there are both advantages and disadvantages to do so. I think the difference really was that we were focusing solely on rural

hospitals at the time. And the multivariate cost of analysis does indeed suggest that costs are lower in rural areas than they are in urban areas. So I guess the suggestion, all else equal, is that perhaps there's cause for this differential.

The problem is that now that we've sort of broadened our look at it, that is not the case with respect to the large urban, other urban split. There really appears to be no justification for that.

So if you went solely on the cost findings, you'd have some support for it with respect to other urban. You'd have some support against it with respect to rural. So there's no clear answer.

And that's essentially what we said in the spring. there really is no clear answer to this.

MR. HACKBARTH: Help me connect that now to the table on page 12. We're saying that the differential is arguably justified because rurals have lower cost. But what

page 12 seems to suggest is that the payments are even more lower.

MR. ASHBY: Right, but some of those payments though, of course, are outside the inpatient arena. On page 12, we're looking at the all Medicare --

MR. HACKBARTH: That is a switch.

MR. ASHBY: Some of the losses are indeed not coming from inpatient. These rural hospitals have a lot of outpatient care and that's where a lot of it comes from, and the SNF and home health as well.

But in the broader picture, in the broader sense, you're right.

DR. NEWHOUSE: I guess I'd like to propose that our presumptive policy would be to go with the empirical data and create a policy around exceptions. Under those, as I hear it now, what that would imply in this domain is that actually the large urban category would get expanded to all urban, and the whole thing would be recalculated. Is that

right, Jack? The empirical data show costs higher in all urban relative to rural and no significant difference between large and small urban?

MR. ASHBY: It is true.

MR. LISK: That's when we had a volume adjustment. When there's no volume adjustment, there really is no significant difference.

DR. NEWHOUSE: We have to show it both ways.

MR. LISK: Because this current system doesn't have a volume adjustment. So when we were doing that modeling, we had the volume adjustment in there, and that's where rural came out lower in that case.

DR. WAKEFIELD: So without a volume adjustment --

MR. LISK: Without a volume adjustment, there basically is not a significant difference between the groups.

DR. WAKEFIELD: The groups being?

MR. LISK: Large urban, other urban, rural --

actually, there probably is slightly significantly higher costs in the other urban group. And the rural group is similar to the large urban. So in fact, the other urban group actually has higher costs. That's from the regression.

That's probably circumstances of market competition for managed care, which is more prevalent in the larger urban areas, and has helped push down costs and, in effect, pushed down Medicare's costs in those markets compared to some of the smaller other urban markets where that's not the case. And I think that's the explanation for that.

MR. ASHBY: So that does change the picture a bit. It seems to suggest that perhaps there's little justification for a differential at all.

MR. HACKBARTH: Joe, would you restate the policy direction that you were --

DR. NEWHOUSE: The general thrust would be a

presumption for what we've called elsewhere the empirical level generally, with exceptions. We can always choose to make exceptions. But I fear we'll always be making ad hoc fixes and then maybe the ad hoc fix will turn out to need another ad hoc fix next year. And we're doing it on out of date data.

Now admittedly, the empirical level is out of date data, but I'm more comfortable with trying to let us be as data driven as possible in our adjustments to payments across types of hospitals. I'd suggest as kind of a guiding principle that's what we do here.

Now admittedly, the empirical level is going to depend on what the total adjustments in the system look like, as was just brought out with the low volume adjustment. But I presume we can handle that.

MR. HACKBARTH: Just so that I understand you're saying, let's do this analysis and if it suggests that there isn't an urban/rural differential, let's eliminate that.

And also, let's go with the empirical number applied to IME as well? Okay.

Other comments?

MR. MULLER: I'd also want to come back to the question on page 12, the Medicare margins and the dialogue I had with Jack earlier about the non-allowable costs. Obviously, if they're trivial then it doesn't change the table in any significant way. If they are at the 3 percent or 4 percent level and the Medicare margins would, let's say, be at zero. Because I mean those costs, and I can understand the policy purpose of saying they're not allowable for Medicare -- for example, some of those costs have to do with advocacy, have to do with philanthropy, and so forth, which are ways to try to secure funding for keeping these institutions going. But they are real costs.

I think very few people should argue that one shouldn't try to raise money for travel, institutions and so forth.

So if they do start approximating that roughly 4 percent level, and certainly I don't know what the number might be, but I know it's more than a trivial number. And therefore if, in fact, the margins are zero, that's an important thing to know.

If the overall is zero, there could still likely be the kind of distributional spread that is on this table. Just everything kind of moves down a little bit. The fact that Medicare has chosen not to allow certain costs does not mean those costs do not exist and certainly they are borne somewhere.

DR. REISCHAUER: Just a question to Jack. Do those costs reappear in the total margin table?

MR. ASHBY: Yes.

DR. REISCHAUER: And so do uncompensated care costs and the costs that Aetna doesn't pay?

MR. ASHBY: Everything.

DR. REISCHAUER: Everything reappears.

DR. STOWERS: I just had a question, Jack. You know, on page 12 again, the IME above costs is a 50 percent number that's a huge factor in this. I know that historically it was originally based on the 1980s numbers. Is this based on current data, that's 50 percent?

MR. ASHBY: We've redone that analysis a half dozen times over the years. The latest one was done for our GME work two years ago, I believe. So it's approximately two years old.

DR. STOWERS: My whole point that since it is such a huge factor in here, I think it would be great to explain that in the text, that this is a current number, that it is justified.

MR. ASHBY: Right, and it is empirically driven.

DR. STOWERS: Because I think in a lot of people's minds, that's an old number. It might be good to explain that.

DR. WAKEFIELD: I just want to share my

perspective that I think that Medicare should be paying its fair share and that fundamentally we ought to have the payment as precise in its remuneration for costs of providing care as we can with an inefficient system.

I'm a little troubled, and so I'll look forward to more discussion about the fact that because rural hospitals have higher total margins that somehow that might mean that we don't have to be too concerned, in a way, paying its fair share within that environment if other payers are paying more. I'm troubled by that notion.

And also, because I think if that is the approach that we take, then we also apply it to other settings, as well. Not just hospitals, but our discussion earlier about long-term care facilities, for example. And frankly, I wouldn't be a bit surprised if we don't have some real problems with Medicaid paying its share of the freight for long-term care Medicaid beneficiaries.

So the question is do you build in that kind of

cost shifting, or do we try and ensure that the payments are adequate.

Secondly, I'd be interested in knowing to what do those higher total margins really translate to, in terms of total dollars? I think on average, for example, rural hospitals have less cash on hand. They tend to have older physical plants. So when you think about higher total margins, but percent of what? What are the real dollars behind that and what can you do with that additional X dollars anyway? So I guess that's another factor that plays in.

A third thing is we do have payment policies that may or may not be accurate in terms of special payment policies for rural facilities, special payment policies that build in some disparities or differences through DSH and IME for urban hospitals, for example.

But I certainly don't see this as being any sort of equivalency given the lay of the land right now. So just

based on what I was hearing a little bit earlier, I really want to make sure that we're not assuming that they're both kind of taken care of. Because if anything, I'd say rurals would probably step up on the plate and be happy to do a switch tomorrow in terms of the payment policies reversed, if there was in fact any sort of an equivalency here.

So I guess just sort of a reaction to some earlier discussion, and I know we'll be coming back to all of it again.

MS. RAPHAEL: The only thing that I want to be sure that I fully understand, based on what Craig said, we're saying that because larger urban areas, in responding to managed care, reduced their costs somewhat or had the ability to reduce their costs somewhat, we believe the base payments for that sector ought to be reduced and Medicare would accrue the benefit of those reductions? What am I missing?

Is that a correct interpretation of what Craig

said?

DR. NEWHOUSE: I'm not sure. There's two different issues One is the issue of the total amount of money in the system which this really goes to, and the other is the distribution of that money among different classes of hospitals.

We've heard the empirical data on the strength of the rationale for the differences in the distribution. So if you did it budget neutral, you would reduce the large urban and you would increase everybody else by some amount, something under a percent, probably.

MR. HACKBARTH: Any other comments? Or solutions? Solutions would be welcome. Okay, I think we're done for now.

Just to make it clear, the floor is open for questions and comments about the outpatient piece, as well. Joe, did you have something you wanted to say on that?

DR. NEWHOUSE: I don't know to what degree other people share this. I had a -- this was really through a glass darkly, or maybe darkly squared. I mean, I didn't know how to react to these numbers. Admittedly, some decision has to be made, but Murray's comment or other people's comment about maintaining stability and Carol's comment about home health may be apropos here. That doesn't lead us to an update number, but probably we ought to try to hold with what we think expectations are for the moment, until we have some data.

I didn't know what to do about the -- but I was interested if anybody had any ideas about -- that was why I brought up the notion that we didn't talk about outpatient.

DR. ROWE: What's going to be the timing of our consideration with respect to these issues?

DR. ROSS: The usual timing. You'll make a decision at the January meeting.

DR. ROWE: So are we going to likely get some

draft recommendations around Christmas or sometime?

DR. ROSS: We're going to try and disentangle, do some forensic work on the transcript here, to see what direction all this leads. I mean, the world is a little bit more complicated this year in past years. Part of that is self-inflicted because of the approach we're taking, and part of that is inflicted by the reality here of trying to look at an overall measure of payment adequacy, figure out how to deal with it vis-a-vis inpatient versus outpatient, thinking also about the distributional issues. And then given that the outpatient system is still new with all the hold harmlesses in place.

We'll produce a couple of recommendations, but if there's specific directions in addition to some of the suggestions for additional cross-tabs and data points that you've asked for, we'll try to get back to you. If there are other things you specifically want on the table, now is a good time to --

DR. ROWE: That's what I'm asking, Murray. I'm actually just trying to -- you know, in thinking about some of the meetings we have, we have discussions of draft recommendations in great detail, and then we think about it, work on it, send some e-mails around and vote on it at the next meeting.

We're far from those discussions of the draft recommendations at this point on these issues. Very big policy issues looming, being lobbed out onto the court here. And so it seems to me that it's going to be hard to get to the point where we're really going to make a decision about this at the next meetings. That's why I was asking whether, in fact, we need to do that, what the schedule is, et cetera.

DR. ROSS: I don't think we go into the January meeting with the notion that we're going to perfect Medicare.

DR. ROWE: I'll come anyway.

DR. ROSS: But we want to get some of these issues out on the table. If the Commission is not ready to make recommendations on it, so be it. But there's a discussion process here. I mean, you've seen a lot of different types of information at the last meeting, at this meeting, that we really haven't encountered before, that the Commission hasn't had a chance to think about.

DR. ROWE: That's my point. So these decisions have to be published when, in the March report?

DR. ROSS: This is the March report. You're on the hook for a payment update recommendation.

DR. ROWE: And that decision, in order that it be published in the March report, has to be made by the January meeting.

DR. ROSS: The January meeting.

MR. MULLER: But given the last chart and the question of redistribution, which obviously becomes politically than almost anything else to deal with. It kind

of makes market basket look tame. So I think therefore having numbers that obviously are in play and move around, even from what we got on Monday to today -- I mean, understanding there's always updating going on, so I'm not criticizing that. But these numbers probably will more a little bit more between now and when we get them next month.

So whether it's the question of what the difference between large and other urban, or between urban and rural. My question about what costs are in or what costs are not in. I think if we're going to go to this kind of framework and really take on some redistributional questions, we should make sure we have time to really kick those numbers around a little bit rather than just kind of saying here they are but they may change in a few days because -- obviously, we're up against a time crunch, but the kind of spread in those numbers.

And this goes back to the SNF discussion, too. It's not just the hospital discussion. Once one gets into

redistribution, one has to have a pretty good sense of what the numbers really mean, rather than just saying in general. I understand Joe's point, he wants to go with the empirical base. But it's very important to know what that empirical base is.

DR. ROSS: But as we talked about throughout the day, it's not so much that the numbers are changing, but there's a fair amount of uncertainty around the numbers you see. But that's one reason for looking at where are the differences large and where are they small? If they're small, then maybe you don't want to spend too much time worry about them. But for some of the large ones -- it's hard to look at those for too long and not seeing that you're seeing some issues with the payment system that ought to be addressed.

With respect to non-allowables, you're not going to know more in the middle of January than you know now, other than to know that that issue is out there and to know

the direction it goes. We don't know the exact size.

MS. BURKE: But, Murray, I think -- just following up on Ralph's point, I think certainly one of the sensitivities -- market basket is always complicated, but the redistribution issues are always hyper sensitive because there are invariably -- I mean, in a market basket everybody is sort of invariably treated similarly.

But in the case of the redistribution, there are clearly winners and losers, all of whom have these strange Congressional district realities. And urban/rural realities are, as you know as well as I do, quite dramatic. So a full understanding of that before we make a decision which we can certainly argue solely based on good analysis, I think we ought to still have the sense of that. It would be helpful to us.

DR. REISCHAUER: I was wondering if we had the margins for Medicare outpatient by hospital type geographic?

DR. WORZALA: You'll have that for January.

MR. KERNS: They're pretty much all the same, negative 17 across the board. But in '02, with the corridor payments, the rurals fall to negative 13. So they tend to do --

DR. REISCHAUER: I was wondering if they were all the same or --

MR. KERNS: They were all the same in '99, within a point of one another. But by 2002, with the corridor payments, the rurals do about four points better and the other groups don't move.

DR. NEWHOUSE: I think this has been our policy all along, but let me just reiterate. Our first job ought to be to present at least the empirical level. And if we think we ought to deviate it for some reason, we say so and say the reason.

Obviously, the Congress can always make the exceptions that it chooses to make, and presumably will do so. But I don't know that we need to try to stay ahead of

the Congress in that respect.

MS. BURKE: No, and I wasn't supposing that. I was just suggesting that we ought not to go into that tunnel blindly and not understanding what the ramifications are. I'm not suggesting we base the analysis solely on what [inaudible].

MR. HACKBARTH: So the one reasonably concrete proposal that we've touched on is doing away with the urban/rural differential and potentially with the add-on of going to the empirical level on IME. So what I hear Ralph and Sheila, and perhaps others, asking for is exactly what does that mean? How much money is going to be transferred from whom to whom?

Is there any way that we can provide some information in advance of the January meeting? As opposed to getting it a day or two in advance of the meeting, give people a chance to chew on it a bit and perhaps ask a few more questions about it?

MR. ASHBY: I was wondering about the same question. If we were to redo the multivariate analysis oriented around the question of the appropriate base rate for the three groups, we most assuredly cannot do that by January. But we can probably summarize some of the results of our two-year-old analysis with and without the volume adjustment that may help the situation.

But we certainly can't redo the analysis in that amount of time. So we're going to have to go home and think about that one, I guess.

DR. ROSS: At the same time, on a number of these questions, paying the empirical level off for the indirect med ed payments, you already know what the impact of that is. You know who it's going to affect. We can give you a quantification, but we can probably even do that with a back of the envelope calculation, $2 billion on an X billion dollar base. But we already know who those hospitals are. We know where they are. And there's really only one more

piece of information, and that's quantifying the percentage impact.

So we could talk about trying to get implications of these various steps, but we already know the implication of going to a single rate because we know who wins and who loses out of that. We know what happens on the empirical level. In some respects, the analytical part of it is not that complicated. The policy and political aspect of it is the difficulty.

MR. MULLER: People are much more willing to engage in -- hypothetically, if the margin is plus 10 percent, people are much more willing to engage in redistribution than if it was minus 10. So if the overall was minus 10 -- because in part people think there's a "excess" to be redistributed. If everybody's kind of underwater, then they get less into redistribution. So therefore, the question of what the margin, in fact, is does influence people's willingness to consider it.

Secondly, the kind of categories that you use, I must say I'm not fully following the discussion on the major urban versus the other urban, exactly how you and Craig ultimately came out on that one. So I'll get briefed on that later.

But the categories that you use become important, too, which ones you use. So I'd like to get a little sense of how you chose the categories, where they come from.

So part of my point is that the magnitude of the numbers also start driving how one looks at them. And so therefore, it's important to see what they are and obviously the kind of distributional question becomes very key, as well.

Again, I'll go back to the SNF discussion, as well. Perhaps this business is a few hours old, it's not as much in our mind right now, but those numbers were much more enormous than the ones we're discussing in the hospitals. So I think as we think about what we want to do, we have to

think about this, as you say, across the board and how we want to make this kind of adjustments.

MS. BURKE: There's also a timing issue. Joe's point is exactly right, that we shouldn't be adjusting things solely on the basis of what the political implications are, or at all. But there are decisions that you can make at the margin as to how quickly you get to what your optimum policy is. If you want to go to the empirical evidence and you want to go to the base number, and you want to go right now, that's one solution.

The other is to get there over a period of time. If there's a shift of $2 billion and you look at what the implications of that are, unrelated to the politics of it the reality is you may just not want to take people down that quickly. And so you have choices along the way.

I think in understanding what the implications are, I mean I know you can do a fairly quick calculation on that piece and know who the winners and losers are. The

question for us, I think, should be in part how quickly do we want to move people to the policy and what's the disruptive effect of having done so over too short a period of time?

There's a perfect answer but there's not necessarily a perfect way to get there.

MR. ASHBY: Dovetailing on that very point, we went into this presentation that at best what we would consider doing this year would be a change to the base rates of maybe a half point or something, to begin moving us in the direction of one rate. And we were not really going to contemplate doing anything major with the IME subsidy because it's such a large issue, both analytically in terms of the number of dollars.

One of the things we might consider is just sort of saying let's take that issue and put it in the next cycle and for this very short amount of time we have focus on this more narrow base rate issue, which seems more viable in the

short run.

MR. HACKBARTH: I agree with everything Murray said. We all know the directional effects and we can do our back of the envelope calculations. I still think it would be helpful though, Murray, if we could have in black and white a common description of this, including some options like do we do just the urban/rural differential? Or do we do that plus IME? And some of the options about pace of change.

We all have our own notions of what those variations are but we ought to have one set of options that we're working from. I think if we only have that when we walk in the door on January 16th, or whatever it is, it's going to make it a lot harder for us to get to a conclusion than if we have it reasonably well in advance of the meeting.

So personally, I'm not looking so much for new numbers to be crunched as for a frame to be put around some

of these issues. Now not just the broad considerations, but here are policy options for the Commission to consider. And the sooner the better.

DR. ROWE: I think I'm basically going to say the same thing, I think, that I heard Jack say. I was looking at this sheet that was handed out earlier today. We were going to look at how they estimate it and how they're going to assess the appropriateness, and here are the six or eight factors.

And I think, with all due respect, Joe's suggestion of by the way, why don't we take this multi-billion subsidy that's paid through the IME payment and get rid of that as a kind of throw it on the table, is a broad discussion which I didn't see on what I expected to talk about. I'm not saying it's inappropriate for MedPAC, but I think it's -- the last time we talked about this it took a couple of minutes and there were a variety of opinions presented and material presented.

So I don't feel an urgency to deal with that issue immediately, unless Congress is expecting an updated opinion from us on that issue. And I would have thought that we would limit the decisions we make, and they're not trivial and they have a lot of major policy implications in them, to these other issues that we talked about, about distribution and et cetera.

MR. SMITH: I think I agree with what Jack just said, although I must say Craig seemed, to me, to put an additional issue on the table by reminding us that when you volume adjust a lot of the geographic differences go away, if I understood him correctly and remember that discussion from a year ago. If that's true, then it's not at all clear to me that the way to deal with the apparent empirical differential is to address it on a geographic metric.

I'd be very cautious, I think I end up where Jack does, although I'd be very cautious about taking steps which assume geographically is the right discriminator, fixing

that, when we've got lurking in the background what may be a much more important observation about what accounts for cost differences. And how we would adjust that is not the same thing as how we get rid of a 1.6 map difference.

So if we know that, and if we're not obliged -- Sheila's point, if we're not obliged to do something dramatic that we don't quite know what it's consequences are, I'd put on the brakes a little bit and try to deal very modestly with decisions that don't take us beyond what we have a real empirical base for, instead of simply some symbols that represent numbers that may not tell us what we really want to know.

MR. HACKBARTH: Any other comments?

DR. REISCHAUER: We've come full circle.

MR. HACKBARTH: In what sense?

DR. REISCHAUER: I think what David is saying is you're backing off of even eliminating the rural adjustment.

MR. SMITH: If, Bob, we thought that eliminating

the rural adjustment would get us to appropriate payments --

DR. REISCHAUER: A more appropriate payment.

MR. SMITH: But if what underlies the current distinct difference is volume, not geographically, maybe the rest of us understand what the consequences of addressing a volume issue through a geographic tool would be. I don't.

MR. HACKBARTH: Wouldn't that argument favor getting rid of the geographic based adjustment? If you feel the real issue is volume, you'd want to move as quickly as possible to a single base rate and then take up the question of whether we, in addition, need to do volume adjustment.

MR. SMITH: I guess I'm cautioned in that regard, Glenn, by the issue that several people have raised, you raised it at the beginning of this discussion, is we continue -- and I think appropriately, as difficult as it is. We continue to wonder what this Medicare margin means in the context of a different set of numbers rooted in a different set of realities for total margin.

We're constantly sort of -- we don't want to suggest that we're looking at total margin, but everybody around this table does. It would be foolish, it seems to me, to say that what we want to get to here is an empirical reality that may make the ability of hospitals operating under certain circumstances to provide appropriate care more difficult.

And maybe I'm slow and shouldn't have missed the November meeting, but I don't think we know enough to say at the moment the right thing to do is to embark on a path, however modulated as Sheila suggested, to get rid of that 1.6. I don't feel like I know enough to conclude that yes, let's go that far and then turn our attention to something else.

MR. HACKBARTH: We're not going to resolve that issue today. Based on the comments thus far, I think there's a significant division on that. So I want to avoid any implication that I'm trying to get you to implicitly

endorse that right now. I'm not.

But we do need to make a decision come January and I'm much more concerned about how we prepare as well as possible for the discussion that needs to happen then. We may end up still divided and we'll have to deal with that.

But I'd like to see some of the issues made -- some of the options now. I think we've got to get beyond the issues to options. I'd like to see them made as concrete as possible and their implications as concrete as possible, so that people can start formulating their thinking well in advance of the January meeting.

DR. ROSS: Let me just add to that. If you go back to the table on page 12, you should take a look at that and we'll bring you back some options, we'll bring you back some analysis. But at the end of the day you're going to have to ask yourself when I look at that 3.8 overall Medicare margin, is that a number you're comfortable with? Because that's going to help guide your update decision.

You're going to have to look at the nine point spread between hospitals in large urban areas and rural hospitals and say are you comfortable with that? And you're going to have to look at the 11 point spread between major teaching and non-teaching hospitals and way are you comfortable with that?

That's not to say you're going to have to resolve it on January 15th or 16th, whatever day we're meeting, but as laying out directions for future work. As staff, we do not want to push you beyond your comfort level. I appreciate it's hard enough having to make these multi-billion dollars decisions on the basis of three-year-old data trended forward.

But those are your decision points.

MR. MULLER: But the discussion you've had the last hour is what categories do you choose? If you look at your page 12, if you look at the middle column and you see a nine point spread between the large urban and rural. If you

look at the third column, you have a 4.2 percent spread, a half a spread.

So part of what you see is that half that spread is driven by a DSH IME decision rather than urban/rural. So you start to ask yourself if more than half of that decision is driven by that, is that really the distinction to make?

I mean, you can cut the column by ethnicity. Some countries are driving out immigrants. So be very careful about what categories you use, because there may be other things driving that. I'm just cautioning you, as you start looking at this urban/rural, there's other things going on there besides just geography.

DR. ROSS: Absolutely. If you look at the appendix in the March report, we slice and dice by about every way you can. What distinguishes these categories, and maybe a couple of others, is they reflect deliberate policy decisions, unlike ethnicity and distance from Omaha, or whatever.

MR. HACKBARTH: I think that the presentation today and the materials that we got in advance very successful in terms of raising issues. Thank you for that.

But alas, that is not enough. I think the final decisions are going to depend, in part, on people's assessment about not just direction but how far, how fast, and that sort of stuff. It's going to take a while, for me at least, to get my arms around that.

So again, I would like to see some concrete options with restatements of their implications as far in advance as possible. And I'd personally rather have the staff spend their time doing that well than generating all sorts of new tables and numbers, because I think that's where the nitty-gritty is and the judgments about these things, not in pushing numbers around.

So we are now finished, for today at least, on payment adequacy. The next issue on the agenda is what's next for Medicare+Choice?

DR. REISCHAUER: We're going to get started on what's next for Medicare+Choice. Scott?

DR. HARRISON: Now that you've taken care of fee-for-service, we'll deal with Medicare+Choice.

Today we will present our continuing refinement of the Medicare+Choice chapter for the March report. I think this slide sums up the mood surrounding the Medicare+Choice program. Plans continue to profess displeasure and leave the program. Beneficiaries are unhappy with the plan exits and the plan benefit reductions. And the Congress is unhappy with the situation and continues to grapple with geographic inequities where some parts of the country have no plans at all. And last, but not least, we at the Commission, along with the economists are unhappy because the payment system is causing market distortions between the Medicare+Choice plans and the traditional Medicare fee-for-service program in local market areas.

MedPAC has recommended that we move to a

financially neutral payment system, meaning that the expected Medicare contribution should be equal between Medicare+Choice enrollees and those remaining in traditional Medicare. This would at least solve the last problem and may help plans remain in payment areas where the payment rates are below risk adjusted fee-for-service spending.

In order to attain a financially neutral payment system we need to do more than just set the rates at 100 percent of traditional Medicare spending. Last month we detailed the need to push forward with the development of an adequate risk adjustment system and we have no news on that front for this month.

Last month we also discussed the graduate medical education payments paid to teaching hospitals that are currently carved out of the calculations of the Medicare+Choice payment rates. In just a minute, I'll turn it over to Ariel to discuss a draft recommendation on that.

Other adjustments we could mention in the chapter

include the use of counties as the definition of the payment areas, which last year we recommended the Secretary examine. In the past, we've also been concerned about how the interaction between the Medicare, Veterans and Department of Defense programs should be treated in rate calculations. Unfortunately, staff have not examined those questions recently and we are unprepared to offer any draft recommendations at this time.

Finally, last month the issue of the limits on beneficiary cost sharing in plans was mentioned as interfering with the plan benefit design. Staff has begun to look into the issue but in our brief examination we've discovered it's quite tricky and we're not ready to share anything with you yet.

Now I'll turn it over to Ariel to discuss a potential recommendation on the GME carve-out.

MR. WINTER: First I'll quickly review how the carve-out works, which I discussed in more detail last

month. Under the carve-out, direct graduate medical education and indirect medical education payments to teaching hospitals are removed from M+C payment rates and paid directly to teaching hospitals when they serve M+C enrollees. This was done based on the assumption that plans use teaching hospitals less and pay them less than fee-for-service.

I will explain how this carve-out appears to be inconsistent with the principle of financial neutrality between M+C payments and fee-for-service spending.

The Commission has said that GME and IME are really payments for patient care provided by teaching hospitals, not for graduate medical education, except for the portion of IME payments that exceeds estimated additional costs in teaching hospitals which you discussed earlier. Because GME and IME represent spending on patient care they should be treated like other fee-for-service spending on patient care when determining M+C rates. Thus,

GME and IME payments should be included in those rates in a financially neutral payment system.

Based on this reasoning we have developed two options for a recommendation for you to consider. The first option reads, Congress should include direct and indirect medical education payments to teaching hospitals in M+C payment rates. The second option is the same as the first option but adds a sentence at the end that reads, however, payments in excess of estimated additional costs in teaching hospitals should not be included.

I'll now open up the floor to your discussion and comments.

DR. ROWE: Can we have an estimate the relative amounts or the relative size of the amount? It's half of the IME, right?

MR. WINTER: Right, the empirical cost -- the IME payment is an adjustment of about 6.5 percent right now to payments, and the empirical level is, I believe, about 3.2

percent. The 6.5 will actually decline to 5.5 percent in 2003.

DR. ROWE: Is the DME included? You're including DME as well here, right?

MR. WINTER: DME we've included in both of those options.

DR. ROWE: How much is DME?

MR. WINTER: Total payments, I'm not sure.

DR. HARRISON: I know that one way to phrase this is that the total that we're talking about is about 5 percent of total Medicare spending.

DR. ROWE: And the part we're talking about in option two --

DR. HARRISON: It might be closer to four, four to five.

DR. ROWE: -- is about how much of that five? Two maybe?

MR. WINTER: 1.3.

DR. ROWE: I'm just trying to understand what's the functional difference between one and two. How much is it?

DR. HARRISON: Option one would probably be 4 to 5 percent.

DR. ROWE: And option two?

DR. HARRISON: Option two then would be probably around 3 percent.

MR. HACKBARTH: So it's a couple of billion dollars.

DR. HARRISON: Yes.

MR. MULLER: But as we know from page 12, the distribution of it is -- so let me -- I just want to make sure I understand our policy last spring which is the teaching hospital adjustment was a reconsideration of what the purpose of that, but it was not -- it was still meant to be a teaching hospital adjustment in the same magnitude as before. You did not decide to reduce it, right? So whether

one calls it a GME, IME discussion as it is in current law or one calls it a teaching hospital adjustment per the report, it's still the same magnitude.

So the logic, therefore, of having a teaching hospital or a GME adjustment, the purpose of it is still to be given for those -- is still intended for those purposes, and therefore should be given to the teaching hospitals, correct?

MR. WINTER: Actually, the Commission has said that GME spending and the portion of IME spending that is directly related to additional cost in teaching hospital should be viewed as spending on patient care.

MR. MULLER: In teaching hospitals

MR. WINTER: Right; exactly.

MR. MULLER: So it's intended to -- whether it's called teaching hospital adjustment, DME, IME, it's intended in the fee-for-service program to be funneled to teaching hospitals.

MR. WINTER: That's right.

MR. MULLER: In this carve-out, whether one calls it teaching hospital adjustment, or under current law the GME, IME, is a payment intended to go to teaching hospitals. So by saying it should now be spread across other places you're changing the logic of the Commission, aren't you? It was not the logic of the Commission to spread that money to other hospitals, was it?

DR. ROWE: We're not saying spread to other hospitals. Is that you're recommendation?

MR. MULLER: I'm just reading what you say here.

DR. NEWHOUSE: I actually disagree with the final conclusion of the staff here so let me say -- I mean, I think it doesn't follow that thus the GME and IME should be included in the AAPCC. So let me say what I think the issue is here.

First, given the carve-out,

the teaching hospital leaves money on the table

unless it lowers its rates to attract M+C customers -- lowers its rates to the M+C plan.

DR. ROWE: I don't understand.

MR. HACKBARTH: Because it only gets the money if it has the patients.

DR. NEWHOUSE: Because it only gets the money if -- otherwise it goes back to Treasury. On the other hand, if the money is not carved out and goes to the M+C plan, then the M+C -- then the teaching hospital doesn't lower its price, the M+C plan has more money with which to afford that price. The same amount of money is in the system either way.

So the real issue I think here is what kind of incentives should the plan face when making a choice between using teaching and non-teaching hospitals. So in one case they face a higher price for teaching hospitals, they'll shift, presumably, some patients toward non-teaching hospitals. There may be some patients that get shifted

inappropriately. On the other hand, if they face the same price there may be some patients that could just as well be cared for in the community hospital who are in teaching hospitals.

So there's two types of errors. The issue is our judgment in how we balance out those errors.

Let me make one other analogy and say, in the amount -- CMS has put some restrictions through regs on the degree of risk that can be funneled down toward physicians. They can't accept more than a certain amount of risk. That's an effort to alter incentives down at the physician level. If the carve-out could be seen as a way of altering incentives at the plan level in a kind of similar way -- that is, you either do or do not want to have the plan face a cost difference, with the money to pay for it if it chooses to pay for it, when making the choice between teaching and non-teaching hospital.

Actually I personally come out on the side of the

carve-out given that analysis, but I think reasonable people could differ depending on how you think, where you think the balance of patients should be between teaching and non-teaching hospitals.

MR. HACKBARTH: So, Joe, you're saying that if the patterns of care stay the same, the financial result will be a wash?

DR. NEWHOUSE: Yes, on average. Obviously any individual hospital --

MR. HACKBARTH: Right, on average. So the public policy question before us is --

DR. NEWHOUSE: If it doesn't remain a wash, then teaching hospitals have in effect given money back to the Treasury, which I assume they'll figure out that they don't want to do that.

MR. HACKBARTH: Right. So the policy question before us is not whether to give money to HMOs or teaching hospitals, but whether we should err on the side of

maximizing latitude for HMOs in terms of appropriate hospital use and patterns of care, or whether there ought to be a public policy in favor of use of teaching hospitals.

DR. NEWHOUSE: Yes, how much -- who should make the call and under what incentives.

MR. MULLER: Let me also say, there's evidence in the prior meetings and literature and so forth that the HMOs don't direct all the care. There's a lot -- Jack and others spoke last month about how physicians in these open networks, even in HMOs, direct a lot of care, make choices. So it's not necessarily the HMO, per se, some central office directing the care. The physicians make the choice. So they may not act the way Joe's rational people might act in terms of not wanting to move the people to the teaching hospitals.

But I'm trying to deal with just what we're saying here in this document and make sure I understand it, which is the purpose of the carve-out was in fact to isolate this

money and say it would go directly to the hospitals. Now I'm saying by the way I read your document here is that you're suggesting otherwise and that you want to blend it back in. So you're basically suggesting a change from Commission policy.

MR. WINTER: Not from Commission policy, no. We're trying to make it consistent with the Commission's policy of financial neutrality. We're saying that the plans should have the discretion to decide how to spend that money that's being spent by Medicare on fee-for-service beneficiaries.

MR. MULLER: Maybe one last -- but the teaching hospital adjustment in the fee-for-service was intended to go to the teaching hospitals, right?

DR. ROWE: Can I ask --

DR. ROSS: Jack, can I do a clarifying thing just before you do because I think it will help a couple of points here, one of which is the set-up for this. This is a

recommendation that follows on the heels, assuming the Commission still feels this way, of financial neutrality for Medicare between beneficiaries in fee-for-service and in Medicare+Choice.

First of all, in the current world, in this world of blends and floors this doesn't, as we've seen last month, make a whole lot of sense, but for quite different reasons. Jack, to your point on what's the magnitude. On the very short run there is no magnitude because of the floors and the blends. This is looking farther ahead.

The second point, I think the gist of the issue is not that it's reversing Commission policy. Joe disagrees with staff and I guess I'm still staff, so I think it does get to what Glenn brought up of the difference in treatment patterns between the two settings, and which one one wants to favor. I don't think it's a question of the views of what Medicare should be doing with its explicit payments for patient care on the fee-for-service side. The question you

face is, do you want to leave plans on the M+C side free to make whatever treatment decisions they make, be it teaching hospitals, other hospitals, or non-hospital care? That's the issue.

DR. ROWE: I think I'd like to at least give my understanding of what this is and see if I can get it corrected because I think I disagree on one point with respect to what Ralph said. I think the original intent was to give this money directly to the teaching hospitals because we didn't believe that the plans would pass it on to the teaching hospitals. And we wanted to give it to them because we thought that the money was paying for teaching. It was intended to go to the teaching hospitals to pay for teaching.

Then somewhere between then and now we discovered, in some epiphanous moment that Dr. Newhouse had, that in fact the money wasn't paying for teaching. It was paying for patient care. That is the important point that I think

maybe Ralph didn't emphasize. So that, yes, we intended it to go when we thought it was for teaching. But now that we've discovered that it's really for patient care, we think that it should go with the other money for patient care that goes into the local market negotiation and the prices.

Do I understand where we are?

MR. WINTER: Yes, that's a good summary of the recommendation, of the point behind it.

DR. STOWERS: This is difficult to explain, but off of what Jack is saying. I think when a hospital fills out its cost report for GME reimbursement or funding it's based on the number of Medicare patients that they take care of. This money was originally money that was put within the Medicare+Choice payments. I don't understand why we're making it so complex except for this patient care thing of, just leave this money in the general GME pool and pay the hospitals where they are based on the number of Medicare patients that they take care, and that would be your

incentive.

This idea of saying that one county is getting more money or particular Medicare money, how we -- there's two things I don't understand. One is, the first is what Jack said. The second thing is how we start worrying about how the GME funding should go within a particular county or not when it was general GME funding in the first place. So I'm having trouble making the leap to the plans distributing money that was not their money in the first place to distribute.

DR. ROWE: I think Joe's point, or the staff's point is it was their money to distribute in the first place and we didn't realize it.

DR. ROSS: Scott, correct me if I'm wrong, actually under TEFRA when we were at 95 percent of AAPCC there was no carve-out. Those GME costs and IME costs were in a capitated --

DR. STOWERS: They were, but maybe they shouldn't

have been and that's why the carve-out is there.

MS. NEWPORT: That's the point. Historically, carving out the GME was based on the old AAPCC. Simultaneous with that we rebased the payments for the plans. We delinked it from fee-for-service. So there's still fee-for-service demand, if you will, for the money but the plans aren't -- and this is the point that we have to keep coming back to, remind ourselves that the plans are not -- on 2 percent counties in particular where most of the teaching hospitals are, that the anomaly here is that you're really restacking the boxes in terms of where the GME payments are going or not going.

So we have, by basing a change on the old AAPCC methodology and not basing it on how we're being paid now, I think that's where the staff gets to on this budget neutrality piece, or payment neutrality. Sorry, I'd better be careful with that. But I really think that the staff recommendation is in alignment with how we're paid now and

not -- the genesis for the GME carve-out was based on the old AAPCC payment problems.

The conclusion here too, some problems with some of the statements in terms of where the incentives are for plans to contract with teaching hospitals. We contract in teaching hospitals in areas where there are teaching hospitals. Where there are no teaching hospitals, guess what? So in those negotiations there are administrators satisfied or not satisfied with the payment rates and therefore they contract with us or don't contract with us.

So I think we just need to be careful here in aligning our understanding of the historical path that we've gone down with the consequences that have resulted here in terms of 2 percent update is a 2 percent update.

MR. FEEZOR: I guess I'm unencumbered either by an epiphany or the board's previous position since I was not here last spring and fall. So forgive me for this. But what I will tell you from trying to deal with managed care

organizations, at least in the commercial market, that I've not been as successful in dealing with this most recent round of cost. Coming from the hospital side is going to be, I think, a new round of products that are going to very significantly and very severely tier the provider, and particularly the provider institutions.

The early indications with some of my vendor partners are that in fact teaching hospitals will be circled and there will be increased pressure on that. So my guess is that we'll see some of that same pressure within the Medicare+Choice be manifested very soon. I just wonder if in fact, it might be cumbersome, but if in fact the carve-out was still maintained but then ultimately was floated, even after the fact, back through the managed care organizations.

In other words, in Janet's case, that the organization is trying to cut its best deal with a teaching hospital, goes ahead and contracts for it, but then there

is, at the end of the year there's an adjustment for how many +Choice patients she took, and in fact there is an additional add-on that flows directly, keeps the monies unique. Now that may --

DR. ROWE: A rebate.

MR. FEEZOR: Yes, to some degree.

DR. REISCHAUER: That's what happens now.

MR. FEEZOR: Is that the way it works now?

DR. REISCHAUER: When Janet goes in she says --

MR. FEEZOR: Somebody is figuring out that there's an extra --

DR. REISCHAUER: -- we'll put this much on the table. But remember, CMS is going to pay an extra $65.

MR. FEEZOR: -- she's got an extra 3 percent or whatever.

MS. NEWPORT: Some hospitals say, so what.

DR. ROWE: Most of them.

MR. FEEZOR: So it still doesn't make enough to

commit.

DR. ROWE: The hospitals say, no, that's for our teaching.

DR. REISCHAUER: But it's exactly what they get for a fee-for-service patient. So if they say, so what, you can --

MS. NEWPORT: We have some hospitals that are asking for 130 percent of fee-for-service.

DR. NEWHOUSE: Assuming the hospital is going to charge its costs, which may be a heroic assumption but that seems like a good starting point, if you give the money to the plan, the plan only gets to keep the dollars if it moves patients out of the teaching hospital. Otherwise it's going to pay the higher cost of the teaching hospitals and the monies will go back to the teaching hospitals. So again I come back to the point, the issue is what incentives does one want to have the plan facing, or the doctors in the plan facing, or the doctors the plan has in its network when it's

making choices about where to put patients.

DR. ROWE: Let me ask you a question, Joe. If we were starting all over again and we hadn't had GME or an epiphany or anything else, and Medicare was going to pay money that was all patient care costs, and there were going to be teaching hospitals, non-teaching, rural hospitals, urban hospitals, whatever, would your recommendation be that some of these patient care costs get paid directly by Medicare to one group of hospitals and not to another group of hospitals, and get carved out of the payment to the plans? Or would your recommendation be that all the patient care monies get paid to the plans so they can negotiate with the different hospitals?

That's where we are now. If we forget the history, that's the question on the table. What would your recommendation be?

DR. NEWHOUSE: As I said, I would have actually gone with the carve-out because I'm more worried about the

error for inappropriately taking patients out of teaching hospitals than the error of inappropriately having too many patients there. But other people could differ. They could say there's a lot of patients in teaching hospitals that don't need to be there and that if we give managed care the choice to manage this they'll save money in appropriate ways by moving people out of teaching hospitals.

DR. ROSS: Joe, I don't want to take a position on this, but if you had folded GME into the base payment rates you wouldn't know what the carve-out was anyway.

DR. NEWHOUSE: You could figure it out. You could always figure out what the higher cost of teaching hospitals was.

DR. ROSS: No. But this is not just about IME. This is about GME and the subsidy as well.

DR. NEWHOUSE: But it's about the higher cost of teaching hospitals.

DR. ROSS: But GME isn't one of the higher costs

of teaching hospitals.

DR. NEWHOUSE: The issue is how to deal with the higher cost of teaching hospitals, how to measure that with --

DR. ROSS: That's an IME concept, not a GME concept.

DR. REISCHAUER: In a funny way, plans should be anxious to have this carved out because the amount that is taken out is based on the average for the fee-for-service sector. Janet could put all of her patients in teaching hospitals, assuming they like that, and the hospital would get paid for all of these. If they had the money themselves because it wasn't carved out they wouldn't have that option. So you have no upside risk at all with a carve-out. Take it to the advertisers, Janet.

[Laughter.]

MS. NEWPORT: Yes, I will. I'm having a little epiphany here. Excuse me just for a second.

Going back to what Ralph said earlier on a different topic about if we were smart enough to allocate things perfectly we'd still have 100 percent. We have percent of premium contracts with all of our Medicare providers except for very rare instances. The reason is the revenue is what the revenue is coming in by member. So de facto, there's no really -- the extra money goes through on the percent of premium contracts, if you will.

MR. MULLER: But it's 6 percent in New York and 100 percent in --

MS. NEWPORT: In the marketplace when 100 percent of the hospitals are teaching hospitals, that goes to Bob's point, perhaps.

MR. MULLER: But most of the country isn't like that.

MS. NEWPORT: Most of the country is not like that. But I think that the issue is that inasmuch as the payment differential carve-out has affected the ability of

counties to have a blend or not have a blend, which in most instances has happened, this doesn't put any real extra money on the table. So the reallocation and our incentives is very different in the size markets that we're participating in. In some markets hospitals, teaching hospitals have come to us and asked for 130 percent of Medicare fee-for-service payments in order to contract with them.

So the economics are much different, and the negotiations are much different in a perfect world. So in rebalancing the scale, if you will, in looking at this, if we're going to go back, as we have advocated, to a payment that is 100 percent of what fee-for-service with appropriate adjustments, which I think we've recommended in the past, then it seems to me that it's parallel to take a look at this in terms of what really does happen with the money on the GME piece of this.

If it is to go to care, I think we need to

understand what has happened here, which was a surprising result for the staff I know in terms of where the money actually ended up going. From some plans that had no teaching hospitals at all to other areas where the teaching hospitals were, that that wasn't the money necessarily from the plans that were in that market.

DR. ROWE: I would say I think that the idealized economic analysis, which is maybe the right analysis, does not reflect at least our experience, in that it is much more local market based. I think that if you're in Baltimore and you're negotiating with Johns Hopkins and you're a health plan, they're not saying, we're going to take 5 percent less because we know it's going to come in from Medicare directly. It's hard to sell a health plan in Baltimore if we can go to all the firms in Baltimore and say, sign up with us and you can go to any place you want in Baltimore except, of course, Johns Hopkins medical institution.

It just doesn't play out the way you guys would

like to think it plays out.

DR. NEWHOUSE: But my scenario assumes competition.

DR. ROWE: It's just not there, I don't think. Maybe it is in some places, but in most places it isn't.

MR. HACKBARTH: Could we do a straw vote here on option one? I'd just like to see where we stand. Unlike the previous discussion around payment adequacy, this really isn't data driven. We may as well get to the bottom line on this as quickly as possible.

So option one is on the table. All in favor of option one?

MR. SMITH: But isn't the real choice, based on this discussion, doesn't it need to include an option three, which is no change?

DR. NEWHOUSE: So you just vote no.

MR. HACKBARTH: Yes, you just vote no. So option one is saying, let's change current law to put it back in

the M+C rates.

DR. ROWE: Totally.

MR. HACKBARTH: All in favor of doing that raise your hand. So nobody is in favor. That makes it easy.

MS. NEWPORT: Are you going to do option two?

MR. HACKBARTH: Okay, option two. All in favor of option two?

It's relatively easy.

[Laughter.]

MR. SMITH: Let's try option three.

MR. HACKBARTH: Which is just leave it alone. I have a guess on the outcome of that. All in favor of option three, which is just leave it alone, raise your hand.

Did I miss you on one of these, Carol?

MS. RAPHAEL: No, I'm still cogitating.

MR. HACKBARTH: So you're abstaining so far.

DR. NEWHOUSE: This is only a straw vote.

MR. HACKBARTH: We are in a position of dealing with a recommendation to change current law that has the support of only a couple commissioners. So what's going through my head is, how do we handle that in our report?

DR. ROWE: Is this a required report?

MR. HACKBARTH: No, we're not required to say anything on this.

DR. ROWE: So there's your answer.

MR. MULLER: There's your answer.

DR. HARRISON: This would just change the shape of the current draft of the chapter, that's all.

MR. HACKBARTH: And you are the only one who cares about that.

DR. ROSS: It will shorten it, for example.

DR. REISCHAUER: You have to convince yourself that the principles of MedPAC are reflected in current policy on this issue here.

MR. FEEZOR: Glenn, if I might, to pick up on

Janet. I had some of the actual writing, the narrative of the chapter, there were some assumptions that I think seemed to be appropriate from a theoretical standpoint but aren't borne out, at least in the market that I'm familiar with, about where we basically are subsidizing floor counties and that therefore there are a lot of plans that are rushing in there is the implication. We haven't seen that. But I'll take that up in a sidebar conversation with staff.

DR. REISCHAUER: I think there's a couple of phrases in there where you used the word subsidy to plans as if there were plans that were laughing all the way to the bank, as opposed to you're creating an unequal playing field.

MS. NEWPORT: So now that we've taken care of this carve-out are going to look at the rest of the chapter, or is that --

DR. HARRISON: That's what I'm here for.

MS. NEWPORT: I felt that we accomplished so much,

so I wanted to stop while we were ahead.

DR. NELSON: I wanted to understand what Allen meant when he indicated that the private sectors plans in areas with academic institutions were circling. I didn't understand exactly what --

MR. FEEZOR: Just the early indication from when we've asked some of our vendor partners to look at some tiered products to reduce the price of our HMOs and our commercial non-Medicare, but Medicare tends to follow that shortly. Clearly in the tiering in the first run of institutions they would or would not include -- academic institutions were noticeably absent in most of the scenarios that have been worked up for us. Am just concerned about that.

DR. NEWHOUSE: Boston is starting to see differential copays on teaching hospitals.

DR. ROWE: In Massachusetts, the Blue Cross plan -- Blue Cross, I believe, payer in the market -- have gone

to their members and said, if you want to go to the teaching hospitals you'll have to pay a copay, which you won't have to if you go to these other hospitals. If there is a perceived difference in quality, which I believe there is, then -- and there may be a real difference in quality. I also believe in that. Then some of the members will be willing to pay that, and some won't. But we're not one of those plans, but that's --

MR. MULLER: Engaging in these predictions I think is a different -- I mean, it's like, reminds me of the old Bolshevik general at the time of the revolution who was asked, what's going to happen? He says, the future is clear, but the past is murky.

[Laughter.]

MR. MULLER: I think these kind of forecast of what's going to happen we can all engage in. I think it's hard not to -- sometimes to figure out exactly -- I just note the kind of debate that was going on here a few minutes

ago as to what really drives referral and choice and so forth. I think there's a lot of differential evidence in different parts of the country as to what happens. I think a lot of people still think that physicians drive choice rather than plans and so forth, and I think all of you conceded that in the discussion last month.

So on the one hand, we might want to go into hypotheticals as to what -- how the world is going to change 180 degrees with these new plans. But my sense is a lot of traditional patterns will continue to do that.

MR. HACKBARTH: Okay, let's proceed with the rest of the presentation.

DR. HARRISON: Now that we have succeeded in resolving these other little pesky adjustment issues and we're ready to implement a financial neutral payment system, beneficiaries and the Congress still have some other goals for the Medicare+Choice program that will not be addressed.

One issue with the Medicare+Choice program that

would remain under a financial neutral payment policy is that beneficiaries living in some parts of the country would have access to Medicare+Choice plans with extra benefits, and beneficiaries in other parts of the country would have no choice aside from the traditional Medicare fee-for-service program. Many beneficiaries and members of Congress view this as inequitable.

Others, however, might not see any problems with the geographic, or so-called intermarket equity, because they see equity in that everyone in the country can join the traditional program for the same Part B premium.

The financial neutral payment policy would not change intermarket equity considerations, although there would be financial equity between beneficiaries enrolling in Medicare+Choice plans and those enrolling in traditional Medicare within each payment area; what we call intramarket equity. The variation in Medicare fee-for-service spending precludes solving both issues simultaneously, and the

Commission has chosen to focus on the intramarket equity because market distortions could arise or continue to arise if they're not solved, and the proper measure of intramarket equity is not really clear-cut.

Other problems. At least in the short run it is unlikely that moving to financially neutral payment rates would result in a significant increase in choice for beneficiaries, especially in areas where no choices currently exist. It's possible that in high cost areas where updates have been constrained rates could increase, and thus encourage plan entry. But most high cost areas have plan choices right now.

Under a financially neutral payment system, low cost areas are likely to see lower payment rates and these areas could lose some of the choices that they have.

Finally, the financially neutral policy MedPAC recommended would not lower Medicare program costs. It wasn't designed to. Under the financial neutrality

principle, in setting the payment rates for Medicare+Choice plans at the level of fee-for-service spending it shouldn't result in significant program cost changes.

If we want to address the other goals some have suggested that we look at competitive bidding. Proponents suggest that adding a competitive bidding process to a financially neutral payment system would be more equitable across the country, encourage greater plan participation, and reduce Medicare costs. Last month we discussed that the Medicare program already features competitive bidding, but the bids do not affect Medicare's contribution in the form of payment to plans.

Although there are many possible competitive bidding models, we are focused on models that would be compatible with a financially neutral payment system. Compatibility requires Medicare contribution to be equal for beneficiaries that enroll in the Medicare+Choice plans and beneficiaries that remain in the traditional program in the

local area. Also, the benefit packages on which the plans bids are based would need to be the same in traditional Medicare and in the Medicare+Choice plans.

As a result of these considerations, we will look in more detail at a model that would determine the government contribution based on the bids of the plans and the local Medicare fee-for-service costs. If the government contribution resulting from the bidding process did not apply to beneficiaries in the traditional Medicare program the financial neutrality principle would be violated.

For simplicity in choosing a model with which to illustrate some of the basic issues, I'm assuming that the government contribution is equal to the lowest bid in the local area. It doesn't have to be but it seems to be an easy illustration.

The traditional Medicare program's bid would be its expected per capita spending in the area. As shown on the chart there, there would be two different market types.

One with only the traditional Medicare program and one with traditional Medicare and at least one private alternative in the market. In markets with only traditional Medicare there would be no difference under the competitive bidding system and the current one; Medicare pays for fee-for-service care and the beneficiary pays the Part B premium.

In markets where there is another bidder, the government contribution is set at the lowest bid. If a beneficiary remains in traditional Medicare, the program pays the fee-for-service costs as before but the beneficiary pays the usual Part B premium plus the difference between the expected fee-for-service costs in the area and the government contribution.

If a beneficiary enrolls in a plan, Medicare pays its contribution to the plan. The enrollee would pay the Part B premium plus an additional premium equal to the difference between the plan's bid and the government contribution. But of course, if the beneficiary enrolled in

the lowest cost plan the bid would be equal to the contribution so there would be no additional premium.

Before I go on to examine what might happen under such a system, are there any questions about how the payment mechanism, this illustration would work?

DR. NEWHOUSE: That's just an illustration?

DR. HARRISON: Just an illustration.

So what would happen under this competitive bidding model and would address any of these other goals that financial neutrality would not address on its own.

Before I talk about the geographic equity I need to note that the very nature of the Medicare entitlement would change here. Beneficiaries would no longer be entitled to receive the traditional Medicare fee-for-service program for a set premium. Instead beneficiaries would be entitled to receive the standard benefit package that is offered under traditional Medicare but would not be guaranteed that those benefits would be delivered through

the broad choice of providers that are available in the fee-for-service program.

As for equity, this competitive bidding model offers a different sense of geographic equity than the current model. All beneficiaries nationwide would have access to the basic benefit package at the same Part B premium and all would have to pay if they wanted a more costly plan, unlike the current situation where all beneficiaries nationwide have access to the traditional Medicare program at the same Part B premium and beneficiaries in some areas have access to plans with extra benefits for no additional premium.

Choice. Would payment rates based on competitive bidding encourage more plan entry? In areas where there are not currently any plans, it's hard to come up with any reasons why a plan that was not already participating would decide to participate under these competitive bidding rules that could only lower payments compared to financial

neutrality. In areas where there are alternatives to the traditional Medicare program, the fact that beneficiaries would have to pay more to remain in traditional Medicare could create more opportunity for other plans to compete for those beneficiaries.

However, authors of a recent study published by Health Affairs have concluded that competitive bidding is unlikely to result in significantly greater enrollment in Medicare+Choice plans. The authors, Ken Thorpe and Adam Atherly of Emory University were kind enough to run a special microsimulation comparison of our financial neutrality recommendation with this illustrative model. They found that the plan enrollment would be virtually unchanged.

Finally, cost growth under this type of system would depend on the results of the annual bidding process, but total spending in any local area would be limited to the level of per capita spending under the traditional program.

In the Health Affairs article, Thorpe and Atherly estimated that a model similar to our illustrative model would generate savings to the Medicare program of close to 10 percent of total Medicare spending. These savings would be produced from additional payments paid by beneficiaries remaining in fee-for-service, and some of those savings would come from lower payments to Medicare+Choice plans.

Assuming that the use of competitive bidding to set the government contribution would result in lower government contributions, and that the beneficiaries in some areas would be required to pay higher premiums to remain in the traditional program, two types of trade-offs would pop up. One type is a trade-off between higher premiums paid by beneficiaries and cost savings. Those cost savings could be distributed either to taxpayers or to all Medicare beneficiaries through lower Part B premiums, or through an improvement in the standard benefit package.

The other type of trade-off would be at the

geographic level. Areas of the country that had plans providing extra benefits at minimal cost would probably not have access to such good bargains after competitive bidding was implemented, and would have extra premiums imposed on their residents who choose to remain in traditional Medicare, while areas of the countries without plans would either be unaffected or would benefit if overall savings are used to lower Part B premiums or to enhance the basic benefit package.

That's what I think the illustration would do.

MR. HACKBARTH: What is assumed about the distribution of risk? For example, in Thorpe's analysis he says that there's going to be a 10 percent savings. Is he just assuming that there's normal distribution of risk across plans? A fear that I would have is that in fact the highest risk patients would stay in traditional fee-for-service Medicare, driving up the premium of that plan, and so the out-of-pocket premiums that people would have to pay

to stay in Medicare fee-for-service could get quite high.

DR. HARRISON: My guess is that what the simulations were based on was past bids that had been submitted. I believe in one of the competitive bidding demos, and I think looking at old ACRs, I would imagine that both of those still had selection in them so probably some of that bid difference would be due to selection.

DR. REISCHAUER: This doesn't assume perfect risk adjustment?

DR. HARRISON: I think it assumes it, but I don't think that the numbers that were in it actually could have supported that because I don't think they could have risk adjusted them.

MR. HACKBARTH: Let's set aside how they did their analysis. Again, my guess is that in the real world there would be not a normal distribution of risk across plans. All the evidence that we have suggests that there would not be a normal distribution risk. So there would be upward

pressure on the Medicare fee-for-service premium as a result of the selection process. Potentially you could get into a spiral where it goes up and up and up and the healthier people keep running out the door and it goes up faster and faster and faster.

DR. HARRISON: I'm not sure that's any different than what we have now because -- especially when 2003 rolls around, we are going to have competitive bidding, but the only difference is where the contribution is set. So you're still going to have relative differences between fee-for-service and plans that could lead to a spiral. I mean, you could have the same problem.

MR. HACKBARTH: But under the 2003 rules there's a limited rebate that they're allowed to give up to --

DR. HARRISON: That's true, up to the Part B premium.

MR. HACKBARTH: So it's a constrained system.

DR. HARRISON: That's right.

MR. HACKBARTH: Whereas if they're actually paying a premium for Medicare that's unconstrained upward, it could just soar upward.

DR. REISCHAUER: I don't think it's -- the dollar value is constrained, but then they can add on benefits. So in effect it's not unconstrained.

DR. ROWE: Let me see if I understand what happens in the current floor counties, because there were floor payments put in in a lot of rural counties particularly to try to keep M+C plans there. As I understand this is going to have a very significant adverse effect on the rural M+C program where it does still exist. Am I right in understanding that there would be no floor counties, there would be no floor payments? Congress has raised these payments up above the Medicare expenditures.

So that what would happen is the payment to the M+C plan would fall to -- if there were no other bidders but one M+C plan, which is often the case in rural areas -- that

it would fall to the current Medicare payments. That would wipe out all the floor county effect; is that right?

DR. HARRISON: Even in our baseline, so to speak, we assume that there are no floors because in financial neutrality there would be no floors.

DR. ROSS: That's what we recommended last --

DR. REISCHAUER: That was our recommendation. You voted for it.

DR. ROWE: No, I'm not against it or for it. I'm just trying to make sure I understand it because so much of our discussion here is about geographical shifts, and what's good for this and what's good for that. I just want to make sure it's clear to everybody what this isn't good for, which is the floor counties.

MR. HACKBARTH: So this is the next step beyond that neutrality.

DR. NEWHOUSE: I think this is obvious, but just to put it on the table, one can have competitive bidding and

then there's still degrees of freedom about both where to set the contribution and how or how much to geographically adjust. So one could set the government contribution at the level of traditional Medicare and say there's rebates or some percentage of the difference rebates to people that choose a cheaper plan. That might exacerbate Glenn's fear about a premium spiral in traditional Medicare.

DR. HARRISON: That is -- our financial neutrality would do exactly that.

DR. NEWHOUSE: I thought I heard you say you were setting the government contribution at the level of the lowest bid.

DR. HARRISON: Right. The difference in adding competitive bidding was to potentially change setting it from the 100 percent of fee-for-service. Our financial neutrality recommendation would set things at 100 percent of fee-for-service.

DR. NEWHOUSE: They're financially neutral.

Because you're just giving a lump sum it's financially neutral either way.

DR. HARRISON: That's right.

DR. NEWHOUSE: The only issue is the magnitude of the lump sum.

DR. HARRISON: Exactly.

DR. NEWHOUSE: That's my point. You can have competitive bidding with a lump sum at any level. And my reading at least of the political tea leaves is that the only way you're likely to get competitive bidding is to set it at the level of traditional Medicare. But that's another debate.

A second degree of freedom is the degree of geographical adjustment in the lump sum. We can adjust it -- implicit in this is that it is at the county level. But obviously you can dial that up or down toward a national average and still have a lump sum, with presumably people in places like Minneapolis then either getting rebates or more

benefits, and people in the Miamis of the world paying more, if you go toward a national average, or not, as one does.

But I don't know where the Commission is headed in this in the way of recommendations. But if we're headed toward a competitive bidding kind of framework then I think we need to lay out that there's clearly several options within a competitive bidding framework. There's not just one option.

DR. ROSS: If you'll pardon the pun, I just wanted to review the bidding on this a little bit and go back to Scott's opening slides which are, why are we doing this at all? The answer is that where the Commission was last year in terms of this principle of financial neutrality gets you some of what you want, but in terms of larger concerns we have about M+C and the geographic issues it doesn't do it for you. So the notion was, is there another mechanism out there, a magic bullet that possibly gets you some of these? At least the take from these slides and this illustrative

option is, it doesn't look like it.

MS. NEWPORT: I would concur with that. I think there's been a lot of discussion, political discussion around competitive bidding, FEHBP program is the magic silver bullet for the M+C program. I think it was part of the request to the staff was we should look at this. And some of this defaults to those huge transitional issues that revolve around any kind of change, much less going from a local, whatever process you call it now, to a transition to some kind of competitive bidding piece, including what's bid where and how you set the payment. There's a lot of political issues around that.

But just being able to lay out some of the, perhaps challenges, it goes back a little bit to earlier discussions to with year after year after year of nothing but change, change, change. It's hard to then fail to understand at that point why there's such lack of interest in continuing to participate in the program. But I think

some of the discussion is valuable.

Whether we put it in the chapter at this point or not may be an open question, but I think it is a debate that we would have been engaged in right now to a greater extent than we have been. But we're sure looking forward to something like that next year or the next two years on this. So how we inform Congress on this -- maybe we need to relook at how we approach this, but I think we need to throw up at least some straw men on competitive bidding in order to be able to answer some of those questions.

MR. SMITH: Scott, let me see if I understand where you ended up. I thought I did and I thought it was right. Let me try to frame it in terms of which beneficiaries are likely to be better off if we go down this path.

It seemed to me that what you concluded is none. That in floor counties beneficiaries would be no more likely to have access to additional benefits or lower costs than

they are today. In more competitive markets beneficiaries might be able to get the same level of service but with their choice constrained, or be charged an additional premium. In which case it sounds to me as if the answer is, in those situations no beneficiary is better off.

We've reduced the ability of a plan to say in a market like New York, in this marketplace we can give you a drug benefit, we can give you additional preventive work, because they would be constrained by the lowest price for traditional Medicare. So in cases where Medicare+Choice is working we would eliminate its ability to work. And in places where it is not working we would not improve them. Is that stated maybe a little more bluntly than you did, but did I get it right?

DR. HARRISON: Yes. The only way people would end up, anybody would end up better off is if the savings were taken from premiums paid in New York and spread across the country in the form of either higher benefits or premium --

DR. NEWHOUSE: But I think that depends on where you set the contribution. If I set the contribution --

MR. SMITH: Remember, I said beneficiaries, not tax --

DR. NEWHOUSE: I'm taking that. So if I set the contribution high enough -- take Minneapolis. I set a traditional Medicare contribution, presumably people that switch to a +Choice plan and take a rebate, think they're better off. Now Minneapolis is unusual, I'll grant you, in many ways. But if you set it at the lowest bid, then almost by definition no beneficiary is going to be better off. He'll be worse off.

MR. SMITH: But don't you have to, in that circumstance, Joe, set it at the lowest bid for the traditional plan? Why on earth would --

DR. NEWHOUSE: For the traditional -- that's not a bid on the traditional plan.

MR. SMITH: Sure it is.

DR. NEWHOUSE: That's just what the cost is.

MR. SMITH: Sure it is. That's the way it would be structured. So in Minneapolis Carol bids 87 percent of the current fee-for-service costs, but in order to do that she has to eliminate the drug benefit and the preventive services that she had previously included in her M+Choice plan in that competitive marketplace. Somebody is going to underbid fee-for-service costs, and that becomes not simply the floor; it becomes the ceiling.

MR. HACKBARTH: I think we may be finished on this subject.

DR. HARRISON: For next month, I assume the draft chapter would end on a note of, this doesn't look like a promising way to go and we would reiterate that we want to head toward financial neutrality.

DR. ROWE: Could you send us a copy of Thorpe's paper?

DR. HARRISON: Yes.

DR. ROWE: That would be great. I think it's convenient that that happens to have been done now.

DR. ROSS: We can even just send you the link.

DR. ROWE: Or you could just send us the reference and we can find it ourselves, if it's too much --

DR. HARRISON: It's the new technology --

DR. ROWE: If it's too much of a burden for you to send us the paper. Just send us the reference.

DR. HARRISON: They didn't actually print it. This is a web paper.

DR. REISCHAUER: It's the web version of Health Affairs.

MR. HACKBARTH: So if you just go to the Health Affairs web site it's one of the first articles there.

DR. ROSS: In return for supplying the toner and the paper you get it a couple days faster.

MR. HACKBARTH: Is that it on Medicare+Choice?

So our last item for today -- and we are now 10

minutes ahead of schedule -- could I have your attention in the audience, please? A little less noise out there would be helpful. So the last item of the day is an overview chapter that would be included in our March report on how Medicare pays for services. The purpose of this chapter is not to recommend new policies but to provide a handy-dandy source of information for those interested in Medicare payment policy.

Sally?

DR. KAPLAN: As Glenn said, this chapter will be in the March report. It will be the first chapter, which traditionally does not have recommendations. Basically, as we all know, Medicare pays for thousands of services furnished to almost 40 millions beneficiaries by over 1 million providers in thousands of counties in the nation. I doubt that you'll be surprised to hear that Medicare payment as a result is complicated, and there are lots of moving parts.

The BBA, BBRA, and BIPA changed almost every payment system that Medicare has, sometimes in multiple ways. So we felt that explaining how Medicare pays for the services it purchases is timely and useful. Also in this chapter we raise current policy issues for each of the payment systems.

What we'd like from you today is your opinion about whether the level of detail in the payment sections is appropriate, and whether the issues are the right ones. We don't plan to present this chapter at the January meeting. It's being sent out for technical review next week. So it's not to say this is your last crack at this chapter, but if we can get some closure on it we'd really like it.

The chapter explains 15 different payment systems. For each system it provides an overview of the system and a description of the products it buys, how Medicare sets payment rates, and then the current policy issues. We'd like to know whether you feel the payment sections provide

you with too much detail, too little detail, or about the right amount of detail.

In other words, when you finished reading the chapter did you want to know more or less? It's a very long chapter. We think it's the right amount of detail but you might not agree with us.

Also we've tried very hard to make the language, as we explained to people, normal English without buzzwords.

MR. SMITH: Sally, it may be the question is, after the question do you know more --

DR. NELSON: Does it stick?

DR. KAPLAN: It may not necessarily stick, but maybe it would be a good reference for people, because 15 different payment systems are very hard to hold in one's brain. I speak as one who holds six in my brain.

MR. HACKBARTH: I think it's very well done. I think it's well organized. There's a nice, consistent approach to each of the different payment systems that makes

it easy to use. I think it will be a terrific reference and I'll keep my copy close by.

DR. KAPLAN: They didn't want me to say that we thought it was a keeper.

MR. FEEZOR: And it ought to be compulsory for all your new members.

MR. HACKBARTH: In fact we can get them in plastic so we --

DR. KAPLAN: Actually we've had a suggestion by one of our independent editors that the big table that we have, that we have it laminated in pull-out so you could put it on your wall. However, I don't think we're going to do that for the March chapter, but you're free to do that yourself.

On the current policy issues which we have up on the screen now, the policy issue section briefly discusses issues related to three objectives: payment adequacy, and an example of that is the pending rate cut in home health that

you discussed this morning. Payment accuracy is the second objective, and an example of that is the RUG-III classification system for SNFs. Then third are other objectives. An example of that might be controlling volume through the SGR which you'll discuss tomorrow.

So our question to you is, are the issues in the chapter the right issues?

DR. STOWERS: I think this is a wonderful chapter as far as reference, and like you said, we'll keep it close. One little problem I had was -- and it pops up -- I hate this is a rural example, but there are others in here in a few places. Like at the bottom of page 11 where we get into a large portion of rural hospitals eligible may receive this benefit inappropriately. I think we agreed in our previous discussion that measured on certain parameters, but maybe measured on other parameters like volume and other things that we don't take into account, that maybe the payments aren't inappropriate.

It's such a great reference chapter, I would hate to get into policy opinions in a chapter that's a good reference. And that happens two or three times, and I just think -- I would hate to get into controversial things within such a good reference chapter. I just bring that up as a -- but other than that, I loved the chapter. It's really good.

DR. KAPLAN: The other two or three times, if you could let us know on sidebar, either by e-mail, et cetera, because I think we've looked at this chapter so much it might be difficult for us to spot it.

DR. STOWERS: That was one example.

DR. KAPLAN: Yes, but if you could e-mail us with the others I'd appreciate that.

MR. HACKBARTH: Any other comments on the chapter? Suggestions?

Sometimes when you get no response it's because people are just worn out. Actually I think in this case

it's probably more because it's very well done, I think. So thank you.

DR. KAPLAN: Thank you.

MR. HACKBARTH: We are now to the public comment period of 15 minutes.

MS. FISHER: I was just going to say, do we get the rest of the time remaining?

MR. HACKBARTH: No. I was anticipating that, Karen. The answer is no.

MS. FISHER: I was going to start and then defer to others and reserve it back.

I just wanted to point out a couple of items. First of all, we appreciate the fact of the chart in Jack's and Jesse's presentation that includes that Table 16 about the impact of possible policy changes in the future so that you can understand what's coming down the pike. I play a little bit of golf and if I were looking at my golf card I'd like to see all those minuses and the zero in the large

urban. Unfortunately, when you're looking at teaching hospitals who are located in large urbans, all the minuses there are not a positive indictment.

We could probably add two more to that list. One is that there has been a technical change that's in the process of occurring with the wage index related to excluding teaching physician costs that will also be reducing the wage index in areas where teaching hospitals are located. That fact is not widely known.

In addition, due to the economy, the number of uncompensated care is likely to increase in the future. So those are two more additional minus signs that will probably be on that list.

We're also glad to hear that the Commission wants to see total margins. I know you all this but it bears repeating that hospitals make decisions about what services they provided, what services they will not provide based on what their total financial bottom line is. Seeing what

those numbers are, seeing what the importance of IME and DSH is for teaching hospitals I think will be useful.

We also agree with the comment made that the IME discussion should be a distinct discussion. I think you're going to otherwise have a very straightforward update discussion in January and adding the IME I think would only encumber that discussion even more.

But I should point out as an aside that on the outpatient side when CMS was putting forth the proposed rule for the outpatient system they did run some regression analyses in terms of looking at teaching intensity and outpatient cost and did find a positive relationship. They decided it wasn't as great as the inpatient side obviously, but they decided not to include an IME adjustment on the outpatient side because they wanted to see how the system would flow out.

Certainly teaching hospitals, due to the transitional corridors and pass-throughs right now, who

knows how they're doing. But when that goes through this issue about teaching intensity and costs on the outpatient side I think is going to come up again.

Finally, on the Medicare+Choice issue, given the Commission's sense that it seems, at least to me, to the extent that this issue does get addressed in your March report, to the extent you've had past recommendations recommending that Medicare+Choice plans receive 100 percent of the fee-for-service payment, that there might need to be some clarification in there regarding the carve-out issue.

Thank you very much.

MR. HACKBARTH: Okay, I guess we're done for today, and we reconvene tomorrow morning at 9:00 a.m. Thank you very much.

[Whereupon, at 4:27 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, December 14, 2001.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, December 14, 2001
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: The first item on our agenda this morning is measuring changes in input prices in traditional Medicare. Tim, are you ready?

MR. GREENE: Good morning. I'll be speaking this morning about input price measurements used by CMS for all its different fee-for-service payment systems. I'll be focusing on measures, price indices used for adjusting for price change over time, as I'll explain.

All the payment systems operated by CMS use input price measures to determine price change. They do it for several reasons. Price indexes play two roles in prospective payment systems. First, price measurement is required to allow appropriate comparison of expenditures across geographic areas. Medicare uses measures such as wage indexes and COLA adjustments to make these comparisons. These are used for setting payments across areas.

I won't be discussing cross-sectional price

measurement wage indexes at this section, but I will be focusing on the second use, which is to determine change over time in input prices paid by providers. These indexes are used both to understand provider cost change and in the process of updating payment rates.

Turning from the why to the how, an input price measurement system provides a single index number for each time period and for the group of providers for which it's defined. To get there we need to decide on three structural components of the price measure.

First, we identify and define cost categories or cost components representing the full range of items purchased by the provider and used to produce health care services. For each component we then define price proxies, or measures of price change over time. We have to use proxies generally because information on the precise prices paid by each different provider type are generally not available. However, we try and match the proxy as closely

as possible to the actual component we have in mind. We'll see as we go along some cases in which this matching is done very well and others in which it's rougher.

Finally, price index or price measure is calculated as the weighted sum of price proxies for the period involved. For this we develop weights to represent the relative importance of each cost category in hospital purchases of inputs. We base the weights on cost report or other economic information, and we recalculate them periodically over time.

Examples of cost components, by the way, might be wages and salaries paid by a hospital or the quantity of pharmaceuticals purchased by a nursing home. And we'd use price proxies such as employment cost index for civilian hospital employees for the first and a producer price index for pharmaceuticals for the latter.

I'll go over a few generic issues dealing with price measurement across sectors, then I'll turn to briefly

look at the specific measures used by CMS in its payment systems. Finally I'll be going through a set of issues for each different measure and recommendation options for you to consider.

Input price indexes should represent market prices faced by providers. These may be based on the prices paid for similar inputs for providers of that type; that is, health care specific measures, or it can be based on information on prices paid in the economy overall. We call those specific or sector specific price measures or economy-wide price measures, respectively.

The former approach is desirable where we have reason to believe that the labor or product market in which the inputs are purchased is distinct from and separated from the market for the entire economy. A good example might be the wages paid for nurses or occupational therapists. The second measure, economy-wide measure, might apply where the markets from which the provider purchases are closely

integrated with the economy as whole, which may include things like salaries for accountants or prices for chemicals overall.

There's a trade-off here between defining a price index. It may be more specific but it would be based on less data and less reliable data for looking at health care prices alone as opposed to economy-wide prices.

The second concern has to do with measurement of prices in a way that gives you a measure of pure price change, because some of the price measures and wage measures published by the Bureau of Labor Statistics will mix changes in price with changes in quantity. You're familiar with this in the context of the wage index in terms of occupational mix differences. We see the same thing here. Some labor costs, some average wage measures will change if wages change or if just the mix of occupations changes from higher cost to lower cost measures. That's going to be reflected in the measure that BLS will publish, and CMS will

use, and that's beyond the control of CMS except in the process of choosing measures.

Finally, a crucial decision in designing a price measurement is the group of providers covered by any specific input price index. A single index could be defined for all the entire health care sector, for a broad sector such as all hospitals, or for a more narrowly defined sector such as psychiatric hospitals. Once again these are trade-offs between data availability and specificity of measurement.

Each Medicare fee-for-service program has its own unique input price index. Now as soon as I say that I have to qualify it by mentioning that several of the smaller payment systems, such as ambulatory surgery centers or labs or ambulances use broad measures like the consumer price index or various subindexes. Now those are obviously rough measures of input price change for health care sectors but they're adequate for these small cases.

However, CMS has developed and uses more refined measures for the major sectors. The first group, which we call market baskets, are indexes of the sort that I was describing earlier with cost components, price proxies, and weights, with one for every major index. The first is the input price index for PPS hospitals. This was developed by analysts at HCFA, now CMS, in the 1970s and was used for various purposes and has been used in the input inpatient PPS since its founding. It's been modified regularly, and rebased and updated, but it's still basically the same index from the '80s.

Now as you'll see, the PPS hospital input price index is sort of the mother of all price indexes, the mother of all market baskets at least. That's intended as a positive description, not the opposite.

Turning to the next, there's a separate price index for hospitals exempt from PPS. This is modeled on the PPS index, uses the same price proxies and cost categories

but the weights differ slightly. So it's built on the PPS hospital market basket. It's also revised over time but it's very similar.

Third, CMS has maintained an index for skilled nursing facilities, SNFs. That has been recently revised substantially and published last July. It too is based on cost categories similar to but differing slightly from those for hospitals.

Now fourth, and here we get to a slightly different variant, CMS maintains a market basket for home health agencies. Not surprisingly, this is a much less ambitious index. While the hospital has 22 components based on 40-some price proxies, this is an index with 12 components. It's slightly different but is similar in structure but much more modest.

Now I include dialysis because it's obviously a major sector, but CMS does not maintain any outpatient dialysis market basket at this time. The Commission staff

has developed an outpatient dialysis market basket that you use for developing recommendations by piecing together pieces from components from hospital market baskets, and you recommended a year ago that CMS develop an outpatient dialysis market basket. BIPA included a mandate to do that and the agency will be reporting next July with results of its development. We look forward to seeing the results there.

Finally we have a very different sort of index that we distinguish from the market basket which is used for physician services. It's called the Medicare economic index. This was developed in 1972 in response to a congressional mandate. It differs in many ways, though it has the basic index structure, differs in many ways from the pure price indices that are reflected in the market baskets.

DR. ROWE: Is that the one that's used in the SGR?

MR. GREENE: Yes, and I'll be getting back to further discussion of it later.

Now I'll turn to cross-cutting issues affecting all the market baskets, as you'll see. This is the treatment of wages, which is typically a very important component in the market baskets. Wages and benefits account for 60 percent of the hospital market baskets and almost 80 percent of the home health market baskets. So what you decide here has a great effect on estimated cost increase over time.

First, in several ways wages can be unique to health care. First, the examples I was giving earlier, we have many groups of employees such as nurses, occupational therapists, who are unique to various health care sectors and whose labor markets can differ greatly. As you know, there have been shortages in many of these occupations, in particular registered nurses in the last year, so we'll see wage developments there that will differ greatly from those in the economy as a whole.

Secondly -- and this is specific to areas such as

hospitals -- we now see changes in historical patterns in wage growth in the PPS hospital sector that's considerably faster than wage growth in the economy as a whole. To again to view health care as different in that way.

I note managed care pressure and payer pressure because historically CMS and other analysts had been averse to basing market basket change on wage indexes for the provider group alone for fear that by making estimated cost change based on behavior of a particular group of providers you could validate and roll forward price and wage setting by that group. The standard concern was, if you use hospital wages to set the hospital market basket, hospitals can, by their own behavior, increase their market basket over time.

That may have been a concern 15 years ago in a context of considerable private sector activity. We think the concern about unwarranted wage setting in matters like this is history. We don't need to worry about that in

choosing wage proxies.

However, we do have several choices to be made in deciding about the wage proxies to use. First, as I indicated, we have to choose between economy-wide measures, or measures for the entire health care sector, or measures specific to any given sector. These could be wages and salaries of service occupations in the economy as a whole in the first case, or there are employment cost indexes for health service workers in general, or thirdly, you could have civilian hospital employees as an example of one that would be particular to a specific sector.

But even after we make those choices, or given those choices, we have to make a choice between the level of definition whether we're looking at health care specific occupations or general labor categories. Again, general labor categories may allow you to be more specific in terms of a type of occupation, but health care specific occupations may be broader but specific to health care.

An example of the first might be computer programmers and the latter might be nurses. What you'd like most would be a measure of hospital computer programmers, but wage series like that don't exist. So again we've got to make choices and make trade-offs in defining indexes.

We've put together some recommendation options in this area. I'll read the more precise language. The Secretary should explore use of more appropriate wage and benefit proxies in all input price indexes. Measures should be as specific to each sector and each sector's labor categories as possible. This addresses the question of appropriate match of proxy with category that I mentioned at the beginning as well as the choice of labor category that I was just discussing.

I don't know how you wish to approach these. Discuss them now --

MR. HACKBARTH: Go all the way through.

MR. GREENE: Fine. PPS-exempt hospital market

basket is, as I say, very similar to the PPS market basket. As currently defined it covers a wide range of sectors: psychiatric hospitals, rehabilitation hospitals, units and so on. However, we believe that these individual sectors or subsectors may differ both in input mix, use of nurses, LPNs and so on, as well as cost trends.

That leads us to recommend that as it develops and introduces prospective payment systems for psychiatric, long term, and rehabilitation hospitals and units, the Secretary should consider developing separate input price indexes for them as soon as possible. This we think is a real concern now because the payment systems are changing from a TEFRA-based basically reimbursement system to prospective payment systems for each.

CMS expressed interest in the idea of developing separate indexes for these sectors when it last revised the excluded hospital market basket in 1996. But as far as I know there's no activity going on in this area.

DR. ROWE: Might I ask a clarification?

MR. GREENE: Certainly.

DR. ROWE: What do you mean by long term? I think it's a non-specific term.

MR. GREENE: It's a category of hospitals, long term care hospitals.

DR. ROWE: Are those chronic care hospitals?

MR. GREENE: Yes.

DR. KAPLAN: Average length of stay is 25 days.

DR. ROWE: And they're called long term care? I thought they were called chronic care hospitals.

DR. KAPLAN: No, they're called long term care hospitals.

DR. ROWE: So that's what you're referring to?

MR. GREENE: Yes.

DR. ROWE: As opposed to long term care, which could be --

MR. GREENE: No. It's a very specific statutory

category.

Finally, on the Medicare economic index. MEI differs from the market baskets and from most pure price indexes by including an adjustment for productivity change before the final index number is calculated. A measure of productivity change in the overall economy is calculated. A 10-year moving average of that measure is developed and higher productivity, growth in the general economy is used to reduce growth in the MEI.

We note that a pure price index such as the consumer price index or the hospital market basket doesn't make adjustments for productivity change like this. We do note that as in the hospital market basket or in decisionmaking in general, you may wish to consider the effects of productivity growth in deciding on -- making an update decision. But you may not want to include it as part of the pure price index of the sort that we're talking today.

Second, MEI proxies are not a good match for the components. There's a component for physician time which is represented by a wage and a benefit index. But the wages and benefit indexes are for non-farm production workers in the economy as a whole. We think that's a poor variable to measure change in physician salaries and benefits.

Third, because the index currently uses a measure called average hourly earnings for production workers to proxy physician wages, salaries and benefits it's sensitive to changes in input mix. Occupational changes in the data measured by the average hourly earnings index can increase its value just as changes in wages paid to those employees will increase its value.

Finally, as used in the current SGR system, the MEI is calculated retrospectively, historically. Unlike the market baskets which use forecasts calculated by a HCFA contractor, the MEI uses historical data. You recommended in the past that this be changed, and you could repeat that

recommendation or note it.

We put together some recommendation options for the MEI that address the major issues I was just discussing. We say, the Secretary should modify the Medicare economic index by using more appropriate measures of wages and salaries and of benefits for physicians than those used in the current index. There are not physician-specific price series that we're thinking of but certainly things more precise, more appropriate than average hourly earnings for production workers.

Secondly, we think that productivity should be handled differently than it is in the MEI. We emphasize that productivity can be considered, should be considered in an update framework but it should not be included as part of a pure price index such as a market basket or the MEI.

Do you wish to discuss these now or do you want to come back to them later? I'm done with my presentation.

MR. HACKBARTH: I think we ought to discuss them.

DR. REISCHAUER: When I was reading this I felt a desire for magnitudes. I wanted to know what's the nature of the problem in terms of size that we're dealing with. I thought with respect to all these different measures that we have, if I went 1995 to 2000 how much do these differ, the SNF one versus the PPS --

MR. GREENE: I'm not sure.

DR. REISCHAUER: -- in the growth over that kind of period?

MR. GREENE: Exempt hospitals and PPS hospitals are very --

DR. REISCHAUER: That's one kind of metric to show how much variability there is now and maybe we're devoting a lot of resources to something that doesn't make a whole heck of a lot of difference.

MR. GREENE: You mean whether you could make do with one index across the board?

DR. REISCHAUER: Yes, right. Then there's the

other issue which is you're talking about some refinements, that this component is a pretty poor proxy for what we really want to get at. Just illustrating that, the example being the production worker income in hourly pay versus you could take the AMA average physician earnings over a five or a 10-year period. Just to give some kind of flavor for what we're dealing with here.

MR. GREENE: I don't know the comparison of those series. For example, comparing the exempt hospitals and the PPS hospitals index you get, looking at the weights --

DR. REISCHAUER: But you're talking about changing weights not about changing anything else. I don't know -- probably the weights offset each other.

MR. GREENE: The exempt and PPS market baskets are very similar but the labor weight is 2 percent higher in one, 2.5 percent, and pharmaceutical weights is going to be 1 percent lower in the exempt market basket.

DR. REISCHAUER: Just one thing. I presumed in

the text you were talking about percentage points, not percent.

MR. GREENE: Yes, things that sum to one. Yes, percentage points.

DR. NEWHOUSE: I thought the major changes here were probably on the MEI, and I agreed with Tim's proposals. I would also say to Bob, I think the point is well taken, some of the changes, as we just said, could be changes in weights which are essentially costless to make, and there's a certain element to face validity to some of the changes as well. But I have no problems with the recommendations.

MR. SMITH: I'm not sure I do either, Tim. But for instance, the production worker wage relationship to physician income sounds screwy. But because it sounds screwy doesn't mean it is screwy. I wonder, what do we know that tells us that this is an inappropriate reference? Is there other data? You've come to the conclusion that it's inappropriate but if you get below the surface it's not

obvious that it is. I just wonder what else we know that would help us think about whether or not investing a lot of money or time in trying to find a different index is going to get us a different outcome.

MR. GREENE: We're not talking about developing new data. Typically we're talking about looking at existing BLS indexes and considering things, wages and salaries of professional and technical workers, things that seem to match the concept better. We're not talking about a major costly and time-consuming effort. We're talking about --

MR. SMITH: I'm just wondering if we've looked at that, if we've looked at some other data available in the wage series, compared it to the AMA data and had seen whether or not it would make any difference if we shifted, or what the orders of magnitude of the difference would be.

DR. NEWHOUSE: The professional series, on the web site at least, only starts in '97 though and goes through '99, so it's hard to know.

MR. GREENE: That's the sort of thing -- for example, in the exempt hospital recommendation we're suggesting that CMS dig into this data and dig into the issues we're talking about. Apart from the MEI we are talking about basically technical recommendations, it's true. These are not major changes. Or possibly the exempt hospitals is a bigger change; separate indexes.

DR. LOOP: Could you explain the productivity adjustment to me a little bit, because it says on page 12, in the absence of reliable methods of measuring it, MedPAC assumes that productivity and technology offset each other, leading to no net increase or decrease of cost. To me that's a pretty big assumption. There's a lot of new technologies that don't make medicine more productive I would think. Could you just explain productivity to me?

MR. GREENE: That's a description of the way we put together our decisionmaking for the overall update framework, which is not the market basket per se but it's

background and relevant to how you treat productivity within the market basket.

We've worked for years in ProPAC and now MedPAC to develop acceptable productivity measures for individual sectors without success, as well as investing a good deal of time, effort, and consultant time into developing measures of scientific and technological change costs. In that sense we haven't been able to develop two series there that are strong enough that we're comfortable with using them separately.

DR. ROWE: When this was discussed yesterday by the staff, balancing productivity and technology, as a proxy for productivity you used reduction in length of stay, as I heard yesterday.

MR. GREENE: Yes.

DR. ROWE: That that was an increase in productivity, a reduction in length of stay per average discharge, and that the savings associated with that were

expected to be balanced out by the increased cost of technology. That's what I thought I heard yesterday in one of the discussions. Is that relevant to this?

MR. GREENE: Yes.

MR. ASHBY: If I could make a comment on that since you're quoting me from yesterday. I think it's better to suggest that productivity and length of stay decline overlap but are not the same. Because the trouble we have always had with length of stay decline is that it represents a combination of real productivity improvements, or at least declines in resources used per stay, but that it also represents a shift of care from the acute setting to other settings. Given that we have to pay for care in those other settings that sort of cancels out any possibility of productivity improvement for that part of it.

But it's clearly a mixture of both. And I have to add to our list of frustrations that Tim talked about. We tried to separate the two and measure that and were pretty

much unsuccessful. So we know that it's both, we just can't tell you the proportions very accurately.

DR. ROSS: Let me just add an addendum to that too, which is they're not synonymous. We would expect productivity growth in all of these different sectors even where we don't have a length of stay analog. In the physician settings you can imagine the use of the Internet or web-based diagnostic techniques would surely have to have increased productivity; you know, faster than flipping through the Merck manual or something like that.

DR. NEWHOUSE: Also the productivity change in the physician sector is likely variable by specialty.

DR. ROWE: I agree with all of this. I just thought I heard yesterday, increases in productivity, for instance, as reflected in reductions in length of stay, we expect to be more or less balanced out by -- I thought that's what I heard. So I was just asking whether that was the proxy or whether it's a piece of it. It's obviously a

piece of it.

DR. ROSS: That was, in part, also just stating a philosophy that this commission and its predecessor commissions have adopted in terms of a 0.5 percent on productivity versus increase in S&TA. You're going to have to make a judgment on the physician side about what you believe are the impacts of increasing technological advances and how much do you want to finance, so to speak, out of productivity growth versus acknowledge through higher payments.

MR. GREENE: Consideration of productivity here is almost a negative consideration. As opposed to laying out the entire update framework, we're concerned about the inclusion of it in the measure that should be a pure price measure rather than one that reflects a variety of factors affecting output costs: productivity, input price change, and so on.

In a sense, a MEI historically and even as it

exists today was not designed and isn't a measure of pure price change like the CPI is. The inclusion of productivity is only the most dramatic way in which it's more of an overall payment-setting measure, which is, in a sense, the way it was originally designed in 1972, rather than a pure price measure as the market baskets, designed later for different uses, are.

DR. ROSS: I just wanted to make a technical response to Bob and David's concerns about the faux precision in all of this. There's some truth to that concern and in fact if the Congress -- if MedPAC followed its new approach of assessing payment accuracy, and allowing errors to offset, and did a good job of it, and made the recommendation every year and the Congress faithfully followed through on what MedPAC recommended, then you might be concerned about doing too much refinement on these narrow price indexes.

But in fact if you let -- if for whatever reason

payments flow from a market basket over a several year period, small divergences can move lots of money. In the hospital sector they're moving billions of dollars.

The second thing is, Bob, a lot of the divergences, the long run is pretty long for differences in trends. If you look at comparisons of wage growth between the hospital sector and economy-wide, they diverge for six or seven years. They've now swung in a different direction. So they don't balance out necessarily over a short period.

MS. RAPHAEL: My question was in line with what Murray just said, because our first recommendation is to explore. We want the Secretary, I presume, to explore the use of more appropriate wage and benefit proxies, et cetera. My question was, explore seems very tepid. If this is a serious issue -- and that's why I had a question about magnitude also. If this is a serious issue and we believe that the current proxies and measures, et cetera, are seriously deficient than we ought to have something that is

a more forceful recommendation. If it's not a serious issue then I question whether or not we ought to do anything.

MR. HACKBARTH: Along those same lines, Tim, what would CMS say, if whoever does this at CMS were sitting right next to you? If these are, in many cases, costless changes and they potentially, at least in the long run, could have serious implications, why haven't they done it?

MR. GREENE: First, as I indicated -- well, if there's someone from CMS to speak they may be able to give you a better response. Many were here yesterday, a number of people, and I thought a few were here.

But first, they certainly are conducting continuing technical analyses of market basket information and every five years or so revise them and update the data and update the categories and change definitions. To some extent we're emphasizing the matter such as matching wage measures more closely to categories that I'm sure they've considered and may or may not agree on. In some areas, as

with the exempt hospital example, we know from their 1996 statements they are considering establishing separate market baskets for the subcategories. So that's the answer there.

The third, on the MEI is a larger policy issue.

MR. HACKBARTH: Clearly the MEI is a different animal altogether. But as Carol says, these questions presumably have been clear to them, just as they are clear to you, and we say something as tepid as, the Secretary ought to explore, Secretary Thompson isn't going to do this in his office. He's going to just hand it to the people who haven't been doing it in the past.

MR. GREENE: That's just the conventional way of framing this, as you know.

MR. HACKBARTH: I know, but if you really think it needs to be changed you'd probably have to say something more forceful than, the Secretary should explore.

DR. NEWHOUSE: Do we know the answer to how much difference it would make? I'm not sure we know.

MR. SMITH: But then it's not clear we ought to recommend -- I do feel that this is a case where being data free is really a huge liability. I just don't know, Joe. If it doesn't make a big difference, then the Secretary has got better things to do. If it does, we ought to --

DR. NEWHOUSE: But I don't think we know that it doesn't make a big difference.

MR. SMITH: But we don't know that it does either.

DR. NEWHOUSE: Right. But we ought to find out.

MR. SMITH: We ought to find out before we recommend --

DR. REISCHAUER: Jack knows. He's standing up.

MR. ASHBY: There is one thing that we do know, and that is that on the issue of the wage proxies we have separate indicators available from BLS that allow us to run this with hospital wages and to run it with economy wages. Over the last seven or eight years the difference has been huge; just a tremendous amount of money has changed hands

over that. For a number of years the disparity went in favor of the hospital industry. But then as the labor shortages starting emerging in the last year or two, there was a knee-jerk reaction in the other direction and the favor went rather significantly to the government side.

So there's a lot of money that we know is involved in that and we're not really suggesting that we want to produce more or less money to the hospital industry. We really just want to get it right because, after all, we don't really know what's going to become of the labor shortage issue. It's kind of subdued at the moment but if it emerges again next year it would be nice to have an automatic reaction to it which is what this recommendation would facilitate.

DR. REISCHAUER: Having a little illustrative table in this that brings this out I think would strengthen the whole analysis tremendously.

MR. ASHBY: That we can do for next time.

DR. ROSS: Just to follow up on Jack's point, because on that first recommendation option, those two bullets, the first one is in many ways a policy call even more than a technical call and what do you think the appropriate weights are to think about this market; look at nationwide versus the hospital sector.

The second bullet is dropping down now to outpatient services, home care, and SNF and there, one reason why nothing has been done is that this wasn't all that relevant in a pre-PPS world.

MR. HEFFLER: I thought I'd try to help clarify some of these issues although I'm not sure I want to do this, but I'll give it a shot here.

MR. HACKBARTH: Why don't you go ahead and introduce yourself.

MR. HEFFLER: Sure. Steve Heffler from CMS and the Office of the Actuary. I would say specifically about the recommendation on the wage and benefit, if you want to

focus on nursing home, for instance, right now a nursing home uses the ECI, or the SNF market basket uses the ECI for nursing homes. So right there you have a wage proxy that is reflective of that industry.

On the hospital side, the hospital wage and benefit proxy is a weighted average of occupations in the hospital. The only difference in an internal hospital measure and the measure that's used is that instead of using the ECI for hospital we do this occupational weighting of ECI, and the occupational mix is a fixed mix of occupations in a hospital.

My guess -- and I will try to answer the question -- we do look at this. We do try to answer these questions, try to address these issues. There are changes over time in the labor markets, and the pressures, and the wage pressures, and the shortages and so forth, and keep an eye on that. But generally I think over a period of time you're not talking about huge differences in what the total market

basket would be.

Now the wage is the biggest share, but we're essentially weighting occupations in the hospital in that fixed mix and we think using the ECI, when we compare the ECI hospital to our occupational mix the differences are not that large. Even though in a given short period of time you can have health wages moving faster or slower than overall wages, it doesn't tend to have a large effect on the market basket. So I don't know if that helps clarify that issue.

Speaking to Glenn's point, this is something we're constantly monitoring and measuring. We do keep an eye on it, and every time we rebase we address these same issues, sometimes when we feel that the index is not picking up what it should be picking up, or is not reflective of what is going on. We rebase more often than a five-year schedule. But each time we do rebase we try to address these same, these issues that have been raised here, and explore these. Whether the Secretary tells us to do it or not, we do try to

address these issues.

The last thing that I would say about the impact of this is, all these updates are set prospectively. They're forecast. So historically you can have some differences in health wages versus non-health wages. But when you're looking at forecast you don't always have -- those differences over time, they tend to narrow when you're looking in a forecast. There's generally not tremendous forecasted differences between the two unless there would be something like a nursing shortage or something like that that was going to cause a major difference in the two series.

So I guess in conclusion I would say that from our research we found that changing the wage proxies, while having a bigger effect than changing the proxy from a smaller part of the market basket, generally would not have a large top-side impact on the overall market basket.

MR. HACKBARTH: Thank you. Two more comments then

we need to bring this to a conclusion.

DR. NELSON: We're going to drill down on physician productivity in the future, I understand that. But I think it will be really important for us to begin with assumptions that aren't possibly false. For example, that e-mail has increased physician productivity. Almost certainly it has not increased the proportion of services for which a physician gets paid as a factor of total work.

Likewise, coding requirements. Compliance plans are often now instructing physicians to put diagnostic codes on themselves, so they're having to learn new coding requirements and documentation requirements. Certainly increases the amount of work without increasing the amount of paid work.

What I'm saying is, we've used ludicrously suspect numbers for productivity in the past, and as we go forward it will be important for us to have some evidence beyond the assumptions as we explore that factor.

DR. LOOP: In reading this I note that the hospital market basket is revised at five-year intervals. I just wanted to formalize this question. We've touched around it here in this discussion, but it seems to me that the pace of medicine is accelerating all the time and you've got IT issues, bioterrorism, labor shortages, innovations with increasing frequency. Is this five-year interval really practical today or do the analysts believe that five years -- there's not much changes in five years? I mean, just labor costs alone in the hospital industry have risen between 9 and 18 percent in the past year.

MR. GREENE: Price/wage changes like that are going to be reflected in the annual data. It's the relative importance that will matter less. Even there -- and this gets to be a technical point -- as something becomes relatively more important, even on a year by year basis, its weight in the market basket will increase even between these rebasing periods. If pharmaceuticals are increasing in

price more rapidly than other items, they become relatively more important even in a time between rebasing.

I think it's also a question of availability of data. Some of the economic data that CMS will use for revisions and rebasing is not available on an annual basis. As Steve just mentioned, when it appears to be appropriate they will revise more frequently than every five years.

DR. NEWHOUSE: There is some evidence on this. We did a study of input price index for treating heart attacks. It showed rebasing made, as I recall, about a percentage point difference per year over rebasing every five years. It was a substantial difference.

MR. HACKBARTH: Okay, I think we're done for today on this. We'll actually take up the formal recommendations and voting in January when we meet.

Next on the agenda is assessing payment adequacy. We have two pieces in this segment. First we'll do physician payments, and then second we'll do ESRD.

DR. HAYES: Good morning. We just talked about input price indexes. The question now is, given a better input price index, what do we do about updating payments for physician services, what do we do about replacing the sustainable growth rate system? So what I'd like to do is to, first, just give you a status report on where we are with that effort to replace the SGR system. And second, to talk about controlling spending for physician services, which is one of the features of the existing system.

So just to recap where we've been with the replacement of the SGR system, recall that the system has two goals: accounting for changes in the cost of providing physician services; and second, to control spending for those services. The Commission, of course, has talked about a number of problems with this system but they tend to come back to one fundamental problem here, which is that these two goals are incompatible. It's difficult to try and update payments to make them consistent with changes in the

cost of services when simultaneously trying to affect the update, move the update up or down because spending is doing something that the system doesn't allow.

So the Commission's position has been to replace the SGR system and to essentially decouple these two goals.

In effect what you've said is that using the update to get the price right for physician services is more important than trying to control spending. We'll talk in a few minutes about alternatives to the SGR system for controlling spending. You're not saying that controlling spending is unimportant, it's just that we need to decouple those two processes.

So how do we get the price right? Of course you've been discussing a way to do that which involves a two-part process: assessing payment adequacy and accounting for factors that affect costs. So the thinking in applying this to physician services the idea would be that going through that process would provide the Congress with the

information needed to make a payment update decision for physician services every year.

So let's talk about what our next step will be on this effort to replace the SGR system. At the January meeting we'll ask you to agree on answers to two questions. First, are payments adequate for physician services? On that topic, recall that you addressed this issue at the November meeting, looked at data from different sources, data on things like the number of physicians billing Medicare, results of the Medicare current beneficiary survey, which includes questions about beneficiary access to care. We also have the results of MedPAC's survey of physicians that was conducted in 1999.

So overall, if we put that information together you have some idea of whether payments were adequate in 1999. One conclusion that could be reached from that information is that payments were not too low in 1999.

What's happened since then? The most important

things we know are the changes in input prices for physician services since then, and we know what the payment updates for physician services have been. In general, or on average I should say, the change in input prices has been greater than the updates.

I don't have the numbers with me, but my recollection is that the change in input prices as measured by the MEI has been in the neighborhood of 2.4 percent a year. The updates have averaged a little bit less than 1.5 percent per year when we include the two relatively large increases in payment rates that happened in 2000 and 2001, and then this most recent scheduled decrease in payment rates for 2002.

The other question that we would ask you to address at the January meeting has to do with factors that will affect costs in the coming year. In this case, given that we're putting out a report in March of 2002, the year of concern is 2003. The hope would be that we can make an

update recommendation for 2003. We will have information on changes in input prices for physician services for that year, and we're also now looking to collect information on other factors that might be affecting costs that would be relevant to that discussion.

So that's more or less --

MR. HACKBARTH: I just wanted to ask for clarification on the first bullet, the payment adequacy. When we compare the actual updates with the change in input prices, how are we going to do that in view of the previous discussion? The MEI has included the productivity factor. We're talking about that potentially not being an appropriate factor for inclusion in an input price measure.

DR. HAYES: So we would take the productivity adjustment out of the MEI for purposes of that comparison. The numbers that I could cite --

MR. HACKBARTH: So the difference between the 2-point-something and 1-point-something will get much larger?

DR. HAYES: Correct.

DR. REISCHAUER: I thought you'd taken that out already. You hadn't?

DR. HAYES: No, had not. So that's what's ahead for the January meeting.

The other points I wanted to make briefly just had to do with the other goal of the SGR system, which is controlling spending. Here, as I said earlier, we're not saying that controlling spending is unimportant by separating this function from the update process. We wanted to address this issue in the March report and I need your ideas on how to proceed with that.

The first thing to keep in mind about controlling spending is that to achieve that requires control of the two components of spending, payment rates and the quantity and intensity of services.

In the case of controlling payment rates, we can contrast our current environment with what the Congress was

faced with in the late 1980s when this issue of spending control was a much more important issue. Then Medicare used a different payment method, the old, customary, prevailing and reasonable payment method based on charges for services. The feeling was that that method gave physicians an incentive to raise charges, and the assumption was that that kind of a system was inflationary.

The Congress replaced that payment method in 1989 with the fee schedule that we have today. A fee schedule that includes, as a know, a set of relative weights, a conversion factor, geographic adjustments. So with a system like that it's possible, despite the recent volatility we've seen in payment rates for physician services, it is possible to control payment rates through the update process. So that's part of the spending equation.

The other part though, the quantity and intensity of services is much more difficult to control. A variety of methods, as you know, have been proposed to address this

issue. The ones that we thought were most relevant to a discussion about replacing the SGR system have to do with methods for reducing fraud and abuse, and reducing either overuse or misuse of services. So I'd like to just take a second to talk about those two strategies and their possible impacts on spending relative to what we have now in the SGR system.

The way it looks, these alternative strategies would provide a weaker form of spending control than what we have in the SGR system. When we think about the SGR, first we can recognize that it is certainly a method for controlling spending. Indeed, it's designed to reduce spending for services. I say that, when we think about projections of changes in spending for physician services and contrast them with growth in the national economy, which is what drives the SGR spending target. Here we see a difference of about 0.6 percent per year. This difference assumes that CMS actuaries are right. That growth in the

quantity and intensity of physician services will exceed growth in real GDP per capita.

Of course, the way the SGR system is structured, that difference will get fed back through to payment rates. It means that on average the payment update for physician services under this system will be 0.6 percentage points below whatever measure we use for the change in input prices. In this case, the way the system is set up, that's the MEI.

So we certainly have a method of controlling spending here which has considerable strength. The question the Commission has asked though is whether this is sustainable, despite the name of the system. The Commission has said that a spending target based on growth in real GDP per capita is too low. Hence, our plan here; one reason to replace the system.

The other strategies for controlling spending would be a bit weaker it appears. Focusing on a couple of

methods that have been used to reduce fraud and abuse, we have coding edits, we have documentation guidelines. Rough estimates of the effects of those methods suggest that they would produce a one-time savings of something like 1 percent of spending for physician services. Contrast that with the yearly savings that come out of the SGR system and that's where we reached the conclusion that this would be a weaker form of spending control.

The other strategy that one could consider has to do with reducing overuse and misuse of services. This is a much more difficult issue to deal with. The Agency for Healthcare Research and Quality is doing a lot of work in this area. Much work to be done. I think it's safe to view this as a long term effort, and effects of this effort would be uncertain.

So that's what we had in mind on addressing the issue of spending control in the March report. If you've got other ideas we'd love to hear them and welcome your

comments on all this.

MR. HACKBARTH: Kevin, just a question about the coding edits and documentation guidelines. When we were doing the regulatory burden report this was one of the hot topics. Are we going to be inconsistent with what we said on the regulatory burden? I frankly can't remember exactly what we ended up saying on this issue there, but --

DR. HAYES: I don't remember any recommendation specific to these.

MR. HACKBARTH: Certainly there wasn't a recommendation, but in the text, as I recall, there was --

DR. HAYES: Right. I think the thing to point out here -- and this is something that we can address in the March report -- has to do with efforts to improve the documentation guidelines. That was an area of much, has been an area of much concern since the early to mid-'90s. CMS has gone through several iterations of the guidelines and efforts are now underway to further revise the

guidelines. The Secretary has said that it's time for the agency, for CMS to rethink the approach here on the guidelines.

So I think there are some things to say. But I guess from a spending control standpoint the point to make here is that we have this estimate of one-time savings. But documentation guidelines of some form are already in place and there's a question of whether we can expect any further savings from this effort.

DR. NELSON: I want to express some caution about articulating these strategies as a means of controlling spending. I don't like the idea of reinforcing what I believe to be a myth in Congress. That if we stamp out fraud and abuse our worries about spending growth are going to go away. We ought to try and eliminate fraud and abuse for the proper reasons: that it's illegal and wrong. It ought to be uncoupled from our projections or our efforts to control spending.

A lot of what is being purported to be abuse is indeed just arbitrary denial of claims because they were coded improperly or because they weren't documented right. The service was delivered; it wasn't paid for, but it wasn't necessarily abuse. The physician or other provider just decided not to fight it. That goes on a lot.

The concern about overuse and misuse, what we ought to be urging is appropriate use. It may very well be that services will go up, because most of the guidelines that aren't currently being met deal with not enough immunizations being given, not enough pap smears or mammograms or other preventive services, colorectal screening. As use is optimalized for the benefit of the beneficiary it may very well be that there will be more added services than a reduction in overuse of services.

Sooner or later somebody in Congress is going to have to point out that if we want to control spending we either have to reduce the benefits, we have to pass on more

of the cost to the beneficiary, or we have to arbitrarily put a cap on it and then live with the consequences, as they did in the Maritime Provinces in Canada where in the fourth quarter of every year payments were reduced by half and all the doctors went to Florida. Those are not particularly palatable things for Congress to consider, but I don't want to reinforce myths that some of them are currently living under.

DR. ROWE: As I recall our prior conversations with respect to this, in addition to all the factors that you mentioned, Kevin, there have been the problem that over the last three years there have been two years in which there, in retrospect, appear to have been overpayments driven by the SGR, and that induced what has been called by some a correction this year, which I think it was minus 5.4 percent or something along those lines. I think we have actually heard here that it might be somewhat less than that, but it came out about a month after our meeting and it

was in that range.

I think when you write up the history and the approaches and the problems with this it would be helpful to have something in a non-judgmental way about these recent changes. Because you can read all this stuff and it's not mentioned at all, and it's kind of a pure analysis of the factors. But the fact is that it hasn't worked. It's not good to overpay, it's not good to underpay, it's not good to have to catch up in one year or in a large way.

The other thing that appears not to have worked is the collars or the corridors in the formula itself. As I recall there is a formula but it's quite wide. It's like minus 7 percent or something that the cutoff is at, so that's a pretty big cut before you have a damping effect on this change. To whatever extent that's accurate you might want to also include something about that as well.

DR. LOOP: Kevin, in that paragraph on controlling spending you mentioned the overuse and misuse. I think in

the quality management chapter that preceded you there was mention by PROs citing that underuse was just as bad a problem if not a bigger one. I don't have that chapter in front of me, but you might check and add a line to that. That it's not only overuse and misuse, but underuse has to be addressed.

DR. STOWERS: I was going to talk about what Jack said so I won't expand on it, but I do think we really need to make a bigger point about how broke the current system is. The other thing I have a problem with, and I know Alan has kind of alluded to this, but this is this emphasis on fraud and abuse in this one specific category of health care delivery when we're not trying to control nursing home costs or home health costs or hospital costs, and we know -- sort of particularly focus in on this in one particular area I think sends a --

DR. NEWHOUSE: Ray, we had huge efforts in home health fraud and abuse.

DR. STOWERS: No, I'm saying we do, and it is important in all sectors including physician services. But to do a huge thing in a particular chapter as the major way of controlling costs in a particular segment I think is well-overemphasized where we are. I think instead of getting contrary to our regulatory burden chapter we could maybe take this from a more positive approach from our quality of care efforts that he's talking about, and quality improvement and so forth, and then let the chips fall where they may.

I just think this chapter could take a lot more positive approach to controlling physician costs than sending the message that we are about fraud and abuse.

DR. REISCHAUER: I thought the other strategies part of this was weak in the sense that these really aren't ways in which, over the long run, we can control spending in Medicare. I'd be in favor of us coming out and forthrightly saying that it is impossible to control spending in Medicare

unless you're going to control it systemwide; one. And there's no way to do this without either underpaying, according to our mechanism, providers, or increasing the burden on beneficiaries. We shouldn't pussyfoot around this topic.

DR. HAYES: That's something that's pretty straightforward. That's a pretty blunt statement.

[Laughter.]

MR. HACKBARTH: It's one of his characteristics.

DR. HAYES: We'll work with that.

DR. REISCHAUER: I'm open to somebody saying I'm wrong in saying, have you thought of, but have you thought of isn't coding edits.

DR. ROSS: But, Bob, that was the opening slide on this, right? There are two goals. They're incompatible.

MR. HACKBARTH: But I, for one, like the direct way of saying that. It has more power the way Bob said it than it had on the first slide. I think the powerful

statement is a useful one.

MR. MULLER: Just to build on Bob's point, and it's a theme we've been discussing for months, and obviously this commission for years. The efforts, when one looks at efforts to control price and efforts to control quantity, two simple things you multiply to figure out what you're spending, we seem to not be willing to take on the quantity issue very directly in the political process because it's so politically difficult to do so. So we do things, as Alan and Ray objected to, by saying, let's see how much there is in fraud and abuse and keep finessing those kind of issues.

But the broader theme -- and I'm not saying that the politics is going to change in any kind of powerful way, but the broader theme of how one gets the right quantity of services inside the program is an issue that I think has to be faced directly, and different efforts can and should be made to see what is an acceptable way of dealing with those issues rather than trying to put them underground and

thinking that it will somehow happen magically, whether through arbitrary reductions in payments or efforts of fraud and abuse control that may not have that kind of effect.

So I think stating the question here more -- and saying, there's a price issue. As you said, it's compatible with trying to put this all -- have a price and quantity control issue in the same. It's not to say that what I call the quantity issue, the use of services inside the Medicare program should be ignored by us, but they should not be submerged into other kinds of mechanisms and have it be thought that somehow it solves the problem.

You then also get the kind of very perverse effects like an SGR of minus 5.4 which comes out of nowhere, for most people who were expecting it, and it causes the system to -- people to think that the system is wrong, as opposed to it becoming a kind of net result of having incompatible objectives inside there. So I would say, I think Bob expressed it very well, and that we should then at

some point think about what kind of appropriate efforts there can be on looking at the quantity of services inside the Medicare program.

MR. HACKBARTH: I'm going to get back to Bob's statement for just a second. I've talked to some people in Congress who, like Bob, think that the cost control mechanisms outlined in the overheads aren't adequate. They're very concerned about the budget implications of the policy changes that we've talked about in the last segment and this one, when you add them up, the dropping of the productivity, even when you factor productivity in later in the analysis it's unlikely to be 1.5 percent, the figure that we've used in the past. We're talking about potentially a huge, a recommendation with huge financial implications for the program here.

So they're very much worried about controlling spending. This stuff won't work. So I know I've been asked, is there any way that the SGR can be fixed; for

example, to reduce the volatility? Presumably you could come up with some way to do that. I think it's very important that we stress Bob's point that the other fundamental flaw, or another fundamental flaw of this is that it applies to only one sector of the program. That is a real problem over the longer run.

So if you want to really control spending, I think you've got to look not just at the physician piece but at a broader system of control.

DR. NEWHOUSE: Although I agree with Bob, I'm concerned about coming off with a tone that controlling spending is the preeminent goal. I think there's a lot of evidence that spending could in principle be cut back at any point in time without any real give-up on the benefit side. I think, however, the evidence that the spending increase over time has been driven by things that on balance we want to buy is compelling to me. Kind of in the speaking truth to power of Bob's remarks, I think the general stance ought

to be that the expectation will be that in fact this program will continue to grow over time as new innovations come on stream that on balance cost money but whose benefits are greater than their cost.

DR. REISCHAUER: I agree with that. But I think what we're really questioning is whether the Congress was wise when it decided that physician services should grow at per capita GDP.

DR. NEWHOUSE: We've said no. All the way back to PPRC we've said no.

MR. HACKBARTH: Others?

Okay, thank you, Kevin.

Next is ESRD. Nancy?

MS. RAY: I am here to discuss updating payments for dialysis services for 2003. We are going to follow the same framework that you have seen several times now at this meeting. The first component of the update assesses whether payment rates are too high or too low. The second part of

the update assesses how much efficient providers' costs will change in the next payment year. The update recommendation that you will be making in January represents the sum of these two components.

The reason that we are dwelling so much on our update and our update framework, the reason that we care so much about it is that we want to ensure that beneficiaries continue to gain access to high quality care.

Now this is not the first time the Commission has considered updating payments for outpatient dialysis services. ProPAC was initially assigned this task back in the early '90s. For today's presentation I will be presenting evidence about adequacy of payments. Second, I will review changes in dialysis policies since 1999. And lastly, we will look at estimated cost changes for providers in the next payment year.

Medicare is the primary payer of dialysis services. About 91 percent of all patients are Medicare

entitled. In 2000, there were roughly about 250,000 dialysis patients. Let me just point out that Medicare is the secondary payer for beneficiaries with employer group health coverage during the first 30 months of dialysis treatment.

Now the three main services that dialysis providers provide to ESRD patients are dialysis. Medicare pays facilities a prospective payment, the composite rate, for the bundle of services which include nursing care, supplies, and certain drugs and lab tests.

Second, providers receive payments for providing certain drugs that are not included in the payment bundle. This includes erythropoietin, and payment for erythropoietin is set by statute. Providers also provide other drugs other than erythropoietin like intravenous iron and vitamin D and injectable antibiotics. For those drugs they get paid 95 percent of AWP.

Third, dialysis patients do receive some

laboratory tests that are paid outside of the payment bundle.

Now for composite rate services, erythropoietin and other separately billable drugs, roughly the proportion of payments that providers receive for these services is roughly 65 percent, according to my calculations, 65 percent for outpatient dialysis services, about 27 percent for erythropoietin, and 7 percent for other separately billable drugs.

Now we have not included separately labs in this analysis. That would required a detailed claims analysis and we just have not done that yet. However, from the SEC filing of one of the national dialysis chains, at least for this one very large national chain we do know that lab services represent about 4 percent of dialysis revenues per treatment. So it is smaller than the separately billable drugs.

So the first question that we looked at is looking

at payment to cost ratios for services furnished by freestanding dialysis facilities. We've provided you data from 1997 to 2000. There's a couple of points I'd like to make about this graph. Payment to cost ratio for composite rate services continues to decline. It went from 0.98 in 1999 to 0.96 in 2000.

By contrast, payments for separately billable drugs and composite rate services exceeded providers' costs by about seven percentage points in 1997 and 1999. This is the second year now we have tried to compare payments and costs for both composite rate services and separately billable drugs.

Now you'll notice that this graph is missing the data point for 2000 for separately billable drugs. We have encountered a little bit of a problem in getting the separately billable drug data, other than erythropoietin, from CMS, but we're still trying to work on that.

Now with respect to payments and costs for

erythropoietin, that actually, we can derive that from the cost report. We at MedPAC had noticed actually an issue with that cost report data. CMS had to go back and give us another file. They have given us additional information this week so you will have that information for the January meeting.

A couple of other points I want to make about this graph. The costs included in this graph represent allowable costs. Providers contend that certain of their costs are not allowable, and that these costs when considered in aggregate are substantial. So let me just go a little bit, let me at least give you what I know about this issue.

Dialysis facilities are required to have a medical director, and the medical director fees Medicare limits according to reasonable compensation equivalent. This was last updated by CMS in May of 1997. So as it stands now, Medicare limits dialysis facilities, the allowable cost, they can claim up to 25 percent of a salary for a medical

director and that salary is set at $143,400. Providers contend that that salary is too low.

For example, this comes out to be, if you divide it by 2,080 hours this comes out to be about $69 an hour. They contend that that's too low, and that instead it should be upwards to about $250 an hour. Now facilities can claim additional -- they can raise the proportion of that 25 percent if they provide written justification to CMS.

Another issue that providers contend is that they are not able to get paid bad debt for coinsurance and deductibles associated with separately billable drugs. Now the use of separately billable drugs has increased steadily throughout the 1990s, so it now represents, as we've already talked about, a substantial amount of revenues for dialysis facilities.

Now on the other hand I also want to point out, however, while providers cannot claim bad debt for separately billable drugs, they are paid 100 percent of

their allowable ESRD bad debt for composite rate services up to their Medicare reasonable cost. By comparison, other facility providers cannot claim up to the full 100 percent. For example, it's my understanding that hospitals can only claim up to 70 percent.

So I think that we need to consider all of the allowable and non-allowable debts when looking at this graph and the impact that they may make on the lines.

MR. HACKBARTH: Nancy, before you leave that, cumulatively what would be the impact of their argument, in that they say, these costs should be included. Therefore, our margins go from what to what?

MS. RAY: I don't have the margin data. What I do have is that their analysis -- and again, this is their numbers, not my numbers. But allowable costs per treatment would increase from about -- right now allowable cost per treatment is about at $8. If you included unrecognized costs like TV, transportation, and so forth, that would

raise it to about $11 per treatment. So a $4 difference.

If you then were to include the non-deductible medical director fees, that would raise it from $11 to $17. So an additional $6 per treatment. Again, that's according to their assumption of paying $250 per hour and then being able to -- up to 25 percent. Now that's their numbers. That's their analysis.

Another caveat about these data. These represent unaudited data. Now you've heard this before from us, that these data are unaudited. But it seemed like throughout the '90s that the data was getting better and better. We make that caveat every year.

This year, there may be a little bit of a difference this year. Congress required CMS to audit 100 percent of dialysis facilities' cost reports. CMS started with the 1996 cost reports. Now 1996 is not on this graph. However, when looking at the new file we are investigating the effect of the audit for the most recent 1996 data. Our

preliminary analysis suggests that a greater proportion of facilities have been audited in this 1996 data file. So we are contacting CMS to get clarification about this and we will report to you back about this issue in January.

These findings I don't think necessarily suggest that the cost base for dialysis services is too high. Some contend that Medicare overpaid for dialysis for much of the '80s and early into the '90s. Providers' costs for composite rate services seemed to have caught up with Medicare's payment rate, primarily because Congress did not update the composite rate between 1991 and 2000.

Lastly, both OIG and the GAO have reported that payments for separately billable drugs and drugs paid according to 95 percent AWP substantially exceed providers' cost. Our data suggests that the positive payment margin for the separately billable drugs is helping at least some facilities to subsidize services included in the composite rate.

We looked at a number of market factors to look at adequacy of payment. The first one is trends in per-unit cost. Providers' cost for composite rate services grew at about the same rate as that predicted by the Commission's dialysis market basket over the 1997 to 2000 time period. Again, this is all according to cost report data allowable cost. Providers' cost increased by about 2.2 percent on average in this time period. By comparison, the market basket increased by about 2.1 percent.

Second, at the same time two important changes have occurred in the dialysis product. The use of injectable drugs such as erythropoietin, iron, vitamin D, and antibiotics during dialysis has increased dramatically throughout the 1990s. For example, total allowed charge for erythropoietin increased from $255 million in 1990 to well over $1 billion in the year 2000. MedPAC's analysis of 1997 to 1999 claims for other injectable drugs other than erythropoietin submitted just by freestanding facilities

also shows significant growth in payments for these services from $281 million in 1997 to $489 million in 1999.

I do want to point out though that these separately billable drugs though have contributed to enhancing beneficiaries' quality of care.

The other change I'd like to point out is that the use of in-center hemodialysis has increased throughout the '90s at the expense of home peritoneal dialysis. This trend has occurred even though per-unit costs for peritoneal dialysis is roughly 10 percent lower than the costs for in-center hemodialysis.

We looked at provider entry and exit. We found that the number of dialysis facilities in the U.S. continues to grow, keeping pace with the growth in the number of dialysis patients. The number of facilities grew by about 7 percent on average annually between 1993 and 2000. This growth occurred in rural areas. They increased slightly, the number of facilities growing from about 23 percent to 26

percent in 2000.

One trend that's very clear is that freestanding and for-profit facilities grew at the expense of hospital-based and not-for-profit facilities. Freestanding facilities increased to 82 percent from 70 percent, while for-profit facilities increased to 78 percent from 61 percent during this time period. Dialysis chains continue to consolidate. They are acquiring independent facilities, and they are also partnering with other third party payers and managed care organizations, often to provide disease management for these organizations.

Now some providers are contending that when dialysis facilities close, the facilities that are closing tend to treat a greater proportion of Medicare and Medicaid patients. This is something that in January we will try to look at. We'll try to look at when facilities do close, the characteristics of those facilities, and hopefully we will report back to you in January.

In terms of changes in the volume of services, dialysis treatments grew steadily in this same time period between 1993 and 2000.

In terms of access to high quality care, a review of the published literature shows no hard evidence that beneficiaries are facing problems in obtaining needed dialysis care. Reports of facility closings tend to be spot problems occurring in a few areas, and they don't appear to be linked to Medicare's policies generally. They tend to be linked to local issues, such as rising real estate prices in certain areas like San Francisco, shortages of technicians and nurses to staff facilities, and state certificate of need regulations.

Quality of care as measured by the clinical performance indicators collected by CMS show continued improvements in the quality of dialysis care as measured by the percent of hemodialysis patients receiving adequate dialysis and those suffering from anemia.

We took a brief look at access to capital. About 80 percent of all dialysis facilities are for-profit, so we looked at their stock price. For-profit stocks of dialysis providers have in large part enjoyed positive investment rates by financial analysts over the last year.

Taken together, on balance nothing suggests that total payments to dialysis facilities are not inadequate although Medicare's payments for composite rate services did not appear to be covering providers' costs in 2000.

Now changes in outpatient policies since 1999. Congress updated the composite rate by 1.2 percent in 2000, and 2.4 percent in 2001. Current law does not include any update for 2002 or 2003.

The other item on the horizon is that BIPA required CMS to submit a report to the Congress on revising the payment bundle by broadening the payment bundle and updating payments for dialysis services. This report is due to the Congress in July of 2002.

Staff did not find any evidence that should suggest that providers' costs are expected to change significantly due to new medical advances, one-time factors, or productivity improvements in the next payment year. I think it's probably appropriate to assume that costs of new medical advances will be offset by productivity improvements, as you were doing for several other services areas.

Now CMS has not developed a market basket yet for outpatient dialysis services. They're working on that right now. ProPAC developed a market basket that uses information from price indices for PPS hospitals, SNFs, and home health agencies. This market basket again predicts that providers' costs will increase by 2.6 percent between 2002 and 2003.

Now the other issue I would like to point out that may affect providers' costs in the next payment year is that the manufacturer for erythropoietin announced a price increase of 3.9 percent. This increase was announced in

2001. I do want to point out though that this price increase does not impact providers equally because each provider negotiates the price of erythropoietin with the manufacturer.

So to summarize, total payments do not appear to be inadequate. Payment to cost ratios for both composite rate services and separately billable drugs was on average seven percentage points -- was 1.07 in 1999. Evidence about other market conditions show no indications that payments are not inadequate.

We would like for you to begin your discussion about whether any adjustment is needed to bring the current payment rates to the most appropriate level, and whether adjustment is needed to account for efficient providers' cost increases in the next payment year.

DR. LOOP: Let me make one attempt to simplify some of this. Erythropoietin, or EPO, is used in 90 percent of the patients, and there's a new EPO that's coming onto

the market that's a long duration EPO.

MS. RAY: Yes. It's come to my attention, however, that that's going to be primary marketed -- the information that certain providers have told me is that the longer acting agent is primarily going to be marketed to pre-ESRD patients and non-ESRD patients, not ESRD patients.

DR. LOOP: But it will catch up real quick, I would think. Anyway, let me go on now.

If there is a better EPO, why not fold that into the base rate?

MS. RAY: The Commission has recommended to the Secretary that we broaden the bundle, and HCFA is working on that study right now. I think it would certainly -- I would think that a longer acting EPO that only has to be given once a week would certainly enhance quality of care, particularly for those patients who are not compliant about coming in three times a week, yes.

DR. LOOP: Right. If it was put into the

composite rate that would seem to get rid of the EPO issue for a while. And if there is an outpatient market basket, which is apparently being developed, I would think because of the increase in technology in this area that it should be updated every year. That would be an index that shouldn't wait five years.

Alan probably should comment on some of this, and Jack if he's been recertified.

[Laughter.]

DR. ROWE: I have a response to that cheap shot. I was board certified so long ago I am grandfathered and don't have to be recertified, to give an idea of how old I am. I have a couple questions.

MR. HACKBARTH: I have Bob, then Jack, Sheila.

DR. REISCHAUER: I actually have a clinical question for Jack and Floyd and Alan. Listening to the presentation, Nancy, and not really knowing anything about this and bringing my tools as an economist to it, I hear you

saying the composite rate is inadequate but to sustain profitability they make it up on drugs, on EPO and other things. So the first reaction that I would have is, clinically, is this providing an incentive for them to use too much in the way of drugs. Floyd says 95 percent of the people use EPO, but is there a question of how much you use?

DR. ROWE: This question has been adjudicated. My understanding is that one of the largest firms, if not the largest firm, was sued by Medicare and there was a settlement in the range of $500 million with respect to questions regarding the overuse of certain medications like EPO and certain nutritional supplements.

So that issue has been resolved, at least in a looking backward way, and my assumption would be that the monitoring is such that to whatever extent there may have been some overtreatment in the past -- and I'm not saying there was, but there was as settlement. To whatever extent there may have been overtreatment in the past, my

expectation is that it is carefully monitored.

We have, in our company, many dialysis patients as well and we're mindful of these incentives and carefully monitor the utilization of these various adjunctive treatments. So I think that that issue is well recognized, Bob.

DR. REISCHAUER: What you said wouldn't make me sleep easy. What it would say is, this egregious overuse is no longer available, but around the edge the incentive still is there. But then if we go to the bundling issue the incentive turns out to be just the opposite, which would be to stint on these. And where you want to draw the line and how much regulation you want to do I think is a difficult kind of issue.

But at a minimum we should want the composite rate to reflect the costs, and what this suggests is that, and Nancy said as much, that 95 percent of the AWP is overpaying for these drugs and we're underpaying for the composite

rate. Rebalancing that at least will reduce some of the incentives. But I have --

DR. ROWE: That's right. But let me respond also to this once more if I may. I think that to whatever extent Floyd's prediction turns out to be true, that there are competitive agents coming on the market with respect to EPO, that's going to reduce expenditures. I know you don't think there are but --

MS. RAY: It's the same manufacturer.

DR. ROWE: But there is another manufacturer in Europe that has released, I think this week, an agent that I think will be licensed worldwide by Glaxco that is a competitor. So I believe it is possible that there will be additional agents. If that happens there will be compression of the margins with respect to EPO, which is what they're living on now, and we'll be left with the inadequate base rate. So it really that much more emphasizes the value of the strategy that you're --

DR. REISCHAUER: But I mean, not necessarily. If we're paying -- EPO we have a flat amount, but these other drugs you're paying 95 percent of the AWP. So from the standpoint of both the manufacturer and the dialysis firm, having the highest AWP possible is the way to maximize everybody's happiness.

I have a supplementary question before you say I'm all wrong on that, Nancy.

MS. RAY: I just want to point out two things. Medicare's payment policy for erythropoietin does provide limits, does limit -- actually it's done by the patient's hematocrit. Providers cannot provide erythropoietin if the patient's hematocrit goes over a certain level. So Medicare does have at least some sort of limit that way.

What we did point out, not in your mailing papers but last year's report, we did point out that this separately billable drugs are not as efficiently provided as they might be. For example, erythropoietin can be provided

either IV or subcutaneously. Subcutaneously, on average, is a lower dose, yet you find most patients receive the drug IV. Some of the other separately billable drugs there are oral formulations. Again, because Medicare doesn't pay for those oral formulations they're given to the in-center patients intravenously.

So I do agree with you that broadening the bundle could help address these issues.

DR. REISCHAUER: Let me go to the second, where I am board certified to talk. You talk about the number of facilities. I'm wondering how useful that is. Don't we really care about capacity? It's sort of like counting the number of food stores when some are ma-and-pa stores and some are Giants. I don't know how this industry operates, but I'd be more concerned about the growth and the shrinkage of capacity than the actual number of facilities.

You mentioned that you were going to do some analysis of the composition of the beneficiaries in

facilities that have closed to see if they were skewed in one way or another. But I thought I read somewhere that like over 90 percent were Medicare eligible anyway, so how skewed can you get?

MS. RAY: The data that providers have shown me -- and again, this was limited to just two dialysis chains. There was a relative small number of closures did show a slightly higher percentage of patients, among the facilities that closed, a slightly higher percentage of patients were Medicare or Medicaid.

Now I think the one issue is, again, they did their analysis by treatments because they have their data broken down by treatments. I think that's important because it goes back to the MSP issue, whether or not Medicare is the primary payer or the secondary payer. Now I don't have that type of data. All I have is whether -- I don't have the MSP information. So the MSP issue and the fact that MSP is for the first 30 months for patients who have employer

group health coverage could affect these data.

MS. BURKE: The question that I had is, in the context of determining a composite rate that is in fact adequate, in addition to EPO, in addition to the other drugs which are largely the iron and vitamin D and antibiotics as I recall, is there anything else missing from the composite rate that we believe needs to be taken into consideration if we in fact are going to adjust that base? That's my first question. Other than drugs, is there a key component missing from the composite rate outside?

MS. RAY: Laboratory tests. But again, we don't have the data; I don't have the data for that yet.

MS. BURKE: So if we were to suggest as policy that we believe more things ought to be bundled, to remove the incentive which varies. In some cases, as you suggest with the case of EPO there's a fairly clear clinical direction that has to be taken. In the other cases it's a little more fluid. Do we in fact have sufficient data to

base a rate on an appropriate mix? If we're going to suggest moving towards a broader composite rate, do we believe in fact that we have sufficient information to know what that rate ought to be based on in terms of the averages of cost of this mix of services?

MS. RAY: CMS right now is studying that issue and I think we would probably be better off waiting for CMS to look at CMS's study on how they are envisioning to broaden the payment bundle.

MS. BURKE: And the timing of that is what?

MS. RAY: It's due to the Congress July of 2002.

MS. BURKE: The CMS study is due?

MS. RAY: The CMS study, right. Congress required CMS to study --

MS. BURKE: To report, right.

MS. RAY: Not to implement, just to study and give them a report about it.

MS. BURKE: So as we look forward to what it is

that we might suggest, what will we be in position to comment on in January, given that? That we think that we ought to move to a broader composite rate but we're not sure what it ought to include? I'm trying to understand the framework in which we are making a decision, knowing full well we in fact don't know yet what that rate ought to be based on because we don't have the data.

MS. RAY: Right. Now last year the Commission did recommend broadening the composite rate bundle. For this year we are asking, for January we are asking you to make an update recommendation for composite rate services only.

MS. BURKE: Absent any of these further longer term adjustments. Just simply the market basket based issues, not whether it's a broader bundle.

MS. RAY: Right.

DR. ROWE: A couple comments. One clinical point. Nancy, first of all, I appreciate, I'm sure we all appreciate your sustained hard work in this area and your

increasing body of knowledge about it. Just on the issue of the EPO administration. It is true that if you give it subcutaneously you get a lower dose. Except there are two problems with that. One is it hurts. While the patient is on the dialysis machine you can give it intravenously and there's no discomfort.

The second is, of course, when the patient is being dialyzed they're anticoagulated. So if you give them a subcu injection you run the risk of them having a hemorrhage or a hematoma. So you would have to give a subcu injection at another time when they're not anticoagulated, which would mean they'd have to come in from home to get the subcu injection of the EPO.

MS. BURKE: Actually, Jack, didn't we do self-administration at some point in the '80s?

MS. RAY: Medicare does pay for EPO whether it's administered in-center, at home, whether it is self-administered.

DR. ROWE: So anyway, there are clinical issues here.

Secondly, I think that when we were talking about hospitals, adequacy of hospital payment rates yesterday we used their share price, their corporate valuations, the creditworthiness, et cetera, of the for-profit hospitals as a measure of their adequacy of payment. So I would think just to be consistent we might -- you mentioned that when you talked about access to capital. But in terms of the analysis of the adequacy of payment you might consider that same analysis to just make it parallel with yesterday's.

Thirdly, there has been a relatively low inflation in the cost, and in fact one year I saw it was 1.8 percent increase in the input costs. I'm assuming that the relatively low inflation rate in these costs is related to increasing reuse of dialyzers, but that's not mentioned. It would be interesting to know whether that in fact is the case.

MS. RAY: We presented some numbers on reuse in last year's report, and I will go ahead and update them and present them to you for January. But the trend has been for increasing reuse. I do want to say though that at least from information providers give me, that there may actually be a change in that trend toward single-use dialyzers in the future.

DR. ROWE: I think that's true, but I don't think that's happened yet.

Next to last, you showed data with respect to anemia, urea reduction rates and hyperalbumanemia. They're all going in the right direction and it looks like quality is increasing quite dramatically, up until '98 at least which is the last data you show. We had been concerned a couple of years ago that what we were seeing compared to Europe was higher mortality rates and that we were seeing a frequent, shorter dialyses in the United States. There was this issue of you get paid per dialysis but you're getting a

shorter dialysis experience, so the total number of hours of dialysis is less, et cetera.

So I wondered whether there had been any change in the duration of dialysis and in the mortality rates, and how we're doing compared to Europe, if you know.

MS. RAY: First of all, comparing mortality to Europe has to be done, I think, very carefully just because of the differences in case mix and who gets treated and so forth. So I guess I'd like to -- there have been studies doing that. There is actually a large study now being done on that. To be honest with you, I am not current with the findings of that study, but I will be and present you that data in January.

With respect to the length of dialysis, recent trends do not suggest that session length is decreasing. But again, I will go and get those data, the most current data and give those to you in January.

DR. ROWE: So it's frequency, session length,

total number of hours of dialysis over time. We want to make sure we're not churning the system here with paying per session for frequent, shorter sessions.

The last point is that I note the migration of dialysis units away from hospitals and not-for-profit status into freestanding and for-profit status. I think that that's not necessarily a bad thing in any way at all. What this is all about is delivering high quality care. I think that it relates to some of the discussion we had yesterday about hospitals not having, not-for-profit hospitals at least not having access to capital. This is a relatively capital-intensive type of unit to establish on the one hand.

Secondly, I think it relates to the economies of scale that the large corporations have, and their purchasing power and what have you, with respect to EPO and dialyzers, et cetera. So I think that probably does explain this.

There's also a fair amount of regulation that you might look into, which is I think highly variable. There

are still states that have basically certificate of need type of programs to apply dialysis stations, and there are other states that do not. That might be an interesting thing for you to look at with respect to entry, et cetera.

Thank you, Nancy.

MR. HACKBARTH: We're down to our last couple minutes here. Did you have a comment, Floyd, directly on this?

DR. LOOP: Nancy, I wanted to also if you can include three things because they do have some longer term implications. One is a progress and quality assessment, because I think that's getting better as it goes on.

The second is some information about frequency of treatment, which Jack mentioned, because there is a -- the number of dialysis episodes per patient, I believe, is beginning to increase. They're going towards multiple sessions a week rather than just once a week.

The third is, as more populations are being

dialyzed, if you could find out what the impact is on dialysis of nursing home patients, because I think that's increasing. I think it was Bob that mentioned something about capacity versus demand. As you know, if there's a niche, somebody is going to fill it. So that's part of the culture of American health care. It's not anything against the for-profit dialyzers.

MS. BURKE: You mentioned or you referenced the increase again in reuse, that we're going back to the old days of reuse; at least I remember them as the bad old days. I don't know whether or not that is something on which we ought to comment at some point, whether that is something that people feel better about, whether in fact that is contributing to reductions in cost, technologies increase. But at least historically that was something that we viewed with a fair amount of suspicion and had a series of real issues, at least in the '80s.

MS. RAY: I will take on the reuse issue for

January.

DR. NELSON: Nancy, are the oral alternatives that you mentioned to parenteral medications a covered benefit?

MS. RAY: No.

DR. NELSON: So one of the reasons for the recipients getting those at the time of dialysis would be that they'd have difficulty affording those as an alternative, outpatient? I guess the point that I want to make is that if indeed we want to encourage alternatives to parenteral use, we ought to comment in some fashion about the composite rate including some coverage for that, for those oral alternatives.

MS. RAY: I agree with you with that, yes. Again, that goes back to our recommendation that we made last year about broadening the payment bundle.

DR. NEWHOUSE: Given that we only have to recommend what we're going to do on the composite rate what I'm about to say may be moot. But to the degree we get into

a discussion of EPO and EPO margins in this report I'd want to make sure that we try to maintain consistency with the chapter we're about to talk about next, which is going to talk about shifting things away from AWP toward transaction prices or fee schedules or what have you, but in any way off AWP. I think we want to try to treat EPO similarly as we're going to treat outpatient technology.

MR. HACKBARTH: Thanks, Nancy. We'll see you in January. You'll come with a big notebook.

The next item on the agenda is paying for technologies in the outpatient hospital PPS.

DR. WORZALA: Good morning. Today, Dan and I will be discussing how Medicare currently pays for technology in the outpatient PPS, alternatives for changing the payment mechanism, and possible draft recommendations for inclusion in the March 2002 report.

Congress was concerned that the 1996 data used to set payment rates in the outpatient PPS did not include the

cost of newer technologies. Therefore, the BBRA mandated that supplemental payments be made when certain drugs, biologicals, and medical devices are used. That also includes radiopharmaceuticals. That additional payment, called a pass-through payment is meant to cover the incremental cost of the item.

Thus, for example, when a pacemaker is implanted the hospital receives the standard payment set for that service plus an additional amount calculated from the hospital's reported cost for the pacemaker if those costs are higher than the device costs already included in the standard payment. Hospitals receive pass-through payments for each eligible item for two to three years. After that the cost of these items are incorporated into the relative weights.

The provision is meant to be budget neutral with spending on pass-throughs limited to 2.5 percent of total payments. However, through administrative action and at the

request of Congress, budget neutrality was not maintained in 2000 or 2001. We're a little bit uncertain at the moment about what will happen in 2002. The Administration has said that they will go ahead and implement the 2002 rates on January 1. However, the committees of jurisdiction did, in the last couple of days, send a letter to CMS requesting that they delay implementation until April 1. So we'll see how CMS responds to that letter.

If CMS does delay and pay on 2001 rates for the first three months of 2002, then the key difference is that the budget neutrality for the pass-through items would not be maintained for those three months. And in a final rule issued in early December, CMS announced that the pro rata reduction required to maintain budget neutrality would be 68.9 percent. So it's a fairly significant difference in the payments for pass-through items depending on how CMS responds to the letter.

MR. HACKBARTH: Chantal, would there be any

reprocessing of the claims? In other words, the ones that are paid in the first quarter under the 2001 rates, would that just be the amount that they're paid forever, or would there be an effort to go back and correct?

DR. WORZALA: They would go ahead and pay the 2001 rates and that would be it. That is one of the principal reasons for requesting the delay is that then there would be no need to either hold claims or reprocess claims.

Despite all this talk we do think that the size of the pro rata reduction in 2002 is a short term issue that should be resolved by the end of 2002 when eligibility for pass-through payments will end for many items. Consequently, we would like to focus your attention today on the systemic problems with the pass-through payments that we have identified previously, and alternative solutions to those problems.

In previous reports and comments on the August 2001 proposed rule MedPAC has identified a number of

systemic problems with the pass-through payment mechanism. First, the payment mechanism provides incentives to raise prices and charges. This is because the pass-through payment amounts are determined based on average wholesale price for drugs and biologicals. However, we know that AWP generally exceeds acquisition cost and can be manipulated by manufacturers.

For medical devices, the pass-through payment amounts are determined based on hospital's charges reduced to cost using a predetermined cost to charge ratio that applies to outpatient services as a whole. Therefore, pass-through payments for devices can easily be increased by increasing charges for those services.

Second, providing a separate payment for certain technology gives hospitals an incentive to use pass-through items rather than comparable items that are bundled into the APC payment. This is due both to the potential for payments above cost resulting from the actual payment mechanism, and

also because marginal payments will increase when those items are used. This is one of the reasons we moved to bundled payment systems because item-specific payments leads to increased use.

Third, the incorporation of excessive pass-through costs into the relative APCs at the end of the pass-through eligibility for a specific item may result in distortion of the relative weights. The pass-through cost data are used to modify the relative weights, and because recalibration of the relative weights is done in a budget neutral manner, services that use pass-through items will have the relative weights increase while the relative weights of services that do not use pass-through items decrease.

This would be appropriate if the cost data collected through the pass-through payments were accurate. However, the incentive for overstated pass-through costs may well result in a distortion of the relative weights in favor of services that use new technologies. This also has a

distributive effect among facilities to the extent that some hospitals are more likely than others to provide services that use the pass-through items.

We did see the effect of this in the fold-in that was in the final rule for 2002. The impact table does that the result of that fold-in would be a significant decrease in payments to rural hospitals and a significant increase in payments to urban hospitals, and especially large urban hospitals.

Just one more fact on that point, which is that small rural hospitals are still held harmless from losses on outpatient payments through 2003, so that that impact which shows the impact of the fold-in, is not the final payment impact. It's just the impact of that fold-in, and it will be at least partially offset by the hold harmless.

MR. MULLER: Chantal, if I could have a factual -- the discussion we had this month I thought went in a different direction so now I'm confused, because I thought

that these were in fact pass-throughs so they were passed through to the supplier, and neither rural nor any other hospital in that sense received it. So you're telling me different this time? What did I misunderstand?

DR. WORZALA: This is the impact on relative weights of folding in costs from pass-through items into the base rate. So the impact that we're seeing on rural hospitals is the decrease in relative weights for APCs that do not have pass-through items. That's because rural hospitals are less likely to provide services for which there are pass-through payments.

MR. MULLER: That's a second order fact, that when they get reweighted hospitals that have a less-than-average utilization of these devices, their APCs get reweighted down. But my understanding was from last month's discussion that these are in fact pass-through payments. So when you use the word, there are incentives for doctors and hospitals to use it, wehther they're large or urban or specialists. I

don't see where there are incentives for that. What am I missing? Why are there incentives if it's a pass-through?

DR. WORZALA: Why are there incentives if it's a pass-through; that's really your question. There can be a difference, for example, on the device side between what a hospital charges versus what they pay for the item. So there is a potential there for some of the money to stay in the hospital. Similarly, for the drugs, the hospital is paid 95 percent of AWP and then the hospital turns around and presumably negotiates their prices for these drugs with the suppliers. So there is a potential for a difference between what the hospital is paid and what the hospital then pays manufacturers.

MR. MULLER: You have more microeconomists in your mind than I've ever seen in any hospitals.

MR. DEBUSK: Let's talk about affecting the small rural hospital. But what about that hospital that is not in that category, it's a small urban and small urban hospitals

use very few pass-through codes that require C-coded products. What does it do to those hospitals?

DR. WORZALA: I would have to double-check the impact table for the exact number but they are significantly negatively affected.

In addition to the payment problems that were noted above, the pass-through creates two additional concerns. First, the special payments for certain items introduces an administrative burden for hospitals and CMS, both of which are already taxed with implementing a new payment system. Hospitals must code the pass-through item separately, and for devices determine which category to assign a particular item. CMS must process these additional codes and determine payments at the hospital level for medical devices.

In 2002, there are over 300 pass-through codes covering more than 1,000 pass-through items. In contrast, there are about 400 codes for actual outpatient services.

Second, the use of pass-through payments in the outpatient PPS creates an additional difference in payments for both services and new technologies across sites of care. This is an issue that MedPAC and CMS have struggled with over the years, and I think one of the reasons for establishing an outpatient PPS was to create a standard that could be used across sites of care, at least between outpatient PPS and ambulatory surgical centers. So there is an issue here of putting an additional difference into place.

That completes my summary of the problems with the pass-through mechanism. Dan will now discussion some options for changing the system.

DR. ZABINSKI: The flaws in the current system that Chantal just discussed suggest that an alternative system for paying technology in outpatient departments may be appropriate. We have identified three possibilities. One option is for CMS to continue the pass-through but make

some modifications. One of these modifications would be to base the pass-through payment on national rates that better reflect acquisition costs than the current cost-based payments.

Also, CMS should make pass-through payments accurately reflect the incremental costs of the pass-through items over the items they replace. Incremental costs are determined as the reported costs of the pass-through items minus the cost of the items being replaced in the applicable APC groups. But the cost of the items in the APCs may be under-represented, so the amount of the incremental cost calculated may be too high than the actual cost.

Finally, the pass-through system should exclude items whose costs are reflected in the data used to determine the base rates. Pass-through payments for these items are not necessary because the base rates already take their costs into account.

A second option we've considered is to remove all

drugs, biologicals, and devices, both pass-through and non-pass-through, from the outpatient PPS and pay for them under a fee schedule. This is similar to the idea I just mentioned of setting national rates for pass-through technology, but in this case we would set payment rates for all technologies, not just the pass-through.

The potential advantage of unbundling all technology like that is a level playing field between pass-through and non-pass-through technology. If you only unbundle pass-through technology, that could give hospitals incentive to either use or avoid pass-through technology in relation to other technology because there would be a very different system between paying the two groups.

The final option is to phase out the pass-through payments and reimburse technology only through the base payment rates in the outpatient PPS. This option would work most effectively if CMS incorporated the new technology in the base rates quickly. This would require a timely system

for introducing new codes for technology, collecting the data on their cost, and then incorporating those costs into the base rates.

Now all three of these options have the advantage that they would remove the incentives for hospitals and providers to increase prices for pass-through technology. Consequently, if we set rates appropriately in options one and two then all three of options would minimize distortions of relative weights in favor of services and providers that use pass-through technology.

But despite these mutual advantages of the three options there are also some importance differences. On this slide here we have a table where in the first column we list the three options and the last two columns we indicate that the modified pass-through option and the fee schedule option would be much more burdensome on CMS and hospitals than the phase-out.

Also, setting appropriate rates for the first two

options may be difficult for CMS. I base that assertion on a study by the General Accounting Office that indicates that CMS has not been successful in setting appropriate rates on the DME fee schedule for two reasons.

First, the classification codes that they use, the HCPC codes often encompass a broad range of products that have a wide price range. Second, the data that they available to set rates may not accurately reflect the market prices of the products. And the agency may face similar problems in setting rates for devices used in outpatient departments because many of them will be paid under the DME fee schedule if they were not being paid under the outpatient PPS.

Now the downside for a phase-out is in the second column of the last row. In particular, under a phase-out we may not pay adequately for high cost new technology, giving hospitals a financial incentive to avoid using them. This may be a weak incentive though because underpayments would

first of all have a limited duration, lasting only until CMS has data to include the cost of the new technology in the base rates. Also the scope of the inadequate payments is expected to narrow because the number of pass-through items is expected to decrease substantially in 2003 and thereafter.

Finally, I think it's possible that this financial incentive would not significantly affect physician's use of new technologies in OPDs. The way I see it is that hospitals would have to influence which technologies physicians used and in what setting, and I'm not sure that they could be successful in taht regard on a large scale.

Now at this point I'll turn it over to the commissioners. I guess the idea is that we'd like to make a decision on which of these options is the most appropriate course of action. Then based on that decision we'll present the draft recommendation.

DR. WAKEFIELD: Chantal, I want to go back to some

of the background that your provided. You had mentioned the hold harmless that's in place for small rural hospitals related to outpatient payment. I think part of the reason why that hold harmless was put into statute was because there was a sense that there needed to be some period of time to collect accurate and adequate data to reflect what was going on in rural hospitals in terms of getting some -- just building as much accuracy into that payment system as possible.

So I guess what I'm asking is a question. A concern I've got is that with the pass-through, the data that are being collected are maybe putting us in a position where we're not going to have a number of years of very good data that serve as a platform to inform the accuracy once we've switched over, the first of January 2004, to shifting those small rural hospitals to APCs and lifting that hold harmless. So what we're seeing potentially is a continued depression of what rural hospitals are getting paid for

outpatient, and we're trying to collect accurate data, then all of the sudden in 2004 we've lifted that hold harmless.

How accurate are the data in terms of reflecting other extraneous things like pass-through payments versus what's really going on in small rural hospitals outpatient services? Can you comment on that? It's tangentially related, but that informs my thinking about where ultimately we go here.

DR. WORZALA: Yes. I would characterize the hold harmless payments more as a transitional mechanism to protect hospitals that were perceived to be vulnerable. Impact analyses of the payment system did show that small rural hospitals in particular, and cancer hospitals in particular would be fairly negatively affected by the new payment system. So those provisions were put in place to give them, in the case of small rural hospitals, a transitional additional payment as they learn to cope, and also I guess to provide time to see how they're faring under

the new PPS and see if they should continue to receive different payment; if they should have some sort of special payment provision.

So I don't know that it relates so much to this, but you are correct that the services that they provide, those payments for those services are negatively impacted, at least in a large scale, from the recalibration of relative weights.

In terms of data availability, we do haev a significant problem in taht CMS has not been able to provide claims data from operation under the outpatient PPS to date. This was due to a programming error that resulted in claims data that are not usable at this point in time. They plan to have a fix to that problem and data may be available in the spring. I do think that it's a significant problem that over a year after the payment system was implemented we don't have any data.

So I don't know that this pass-through mechanism

really affects data availability. It's more the other issue that really affects data availability.

DR. WAKEFIELD: If I could just follow up, that's helpful to know because I really thought that part of -- I'll go back and check this, too. I really thought that part of why that hold harmless was implemented was because the data that were available, that hospitals had been collecting, rural hospitals had been collecting and reporting were really inaccurate. There wasn't an incentive for them to provide accurate. So this provided a window knowing that, you're going to be transitioned over. You'd better be collecting accurate data so we've got a base to work from that's as precise as it can be.

Then my concern, if that was the case, that overlaid on top of that is what's happening as a result of what we're talking about today. So is it going to get them to the point where in fact their data are accurately reflecting what's going on in outpatient? But we can have

that discussion offline and explore it further. But if that is the clear, and it clearly has implications I think beyond, perhaps beyond what you just described.

DR. WORZALA: Yes. Very quickly, in order to be paid under the outpatient PPS they do have to be coding claims accurately. So that does give them the incentive to code more accurately than in the past. So when and if the claims data become available it should be more uniformly coded across hospital types.

MR. MULLER: The original purpose of this policy, I take it, is to make sure the beneficiary gets the right services in the eyes of the Commission. In some ways I see this somewhat comparable to outlier policies where one wants to take into account, when there are extraordinary costs, that there not be a willingness to avoid the appropriate treatment just because the cost of several standard deviations outside normal costs.

So when we use words like level playing field and

so forth, I think we should keep reminding ourselves the payment policy is not the end of the program. The payment policy is the servant of the programmatic goals. Therefore, we would want, as we look at our considerations here, to neither have clinicians and institutions misusing, overutilizing services because there's some kind of payment incentive. On the other hand, we don't want to just save by having just standard pricing. That appropriate items may be much more costly not be used.

So as I think about our alternatives here, if we're very much concerned about the kind of pricing -- one of the discussions we had last month is maybe go more for a fee schedule on some of these. But I would be hesitant to get into a system where we just totally move away from any kind of outlier payments and therefore avoid the use of the appropriate technology.

There's obviously a desire on the part of physician and patient to use this technology that's

beneficial to the beneficiary. So if we look at only avoiding some of the possible consequences of either AWC pricing and so forth, we don't want to go so far, therefore, to take away the incentive to use the right technology.

But I sometimes get a sense of -- and still being relatively new here -- the language we use here is very much a language where we focus so much on the incentives of payment and almost use that as a way of overriding appropriate clinical judgment. So I'm concerned that we use the language of clinical judgment as well the language of payment philosophy. It just kind of radiates a staff work we have that has kind of the payment policy as the end of the program.

MR. HACKBARTH: Can I ask a question related to this? In the case of outpatient services, Congress elected to do a pass-through for new technology to make sure that people weren't deprived of it. We don't use that approach on the inpatient side. What was the rationale for saying

that we should deal with outpatient differently, and how valid is that, that rationale?

MR. MULLER: That's why I used the outlier example, and Mary and others can comment on that. In some sense, the outlier provisions allow for some of that in the inpatient side. It's not specifically addressed to that, but the outlier is meant to cover other things in addition to new technology. But it allows for a variety of factors to allow for special costs and cases.

MR. DEBUSK: May I take a shot?

DR. WORZALA: Excuse me, just one factual item. There is an outlier policy in addition in the outpatient PPS.

MR. DEBUSK: In the DRG, I think for new technology often times for the DRG they issue a new DRG to increase the payment for new technology, or improved technology.

MR. HACKBARTH: Doesn't the same mechanism exist

for the outpatient PPS?

DR. WORZALA: Yes. On the inpatient side, some might say as a follow-on to the pass-through on the outpatient side, BIPA did introduce a similar mechanism on the inpatient side. It is different and one might say there was some learning that was done in that the inpatient pass-through legislation states that payments should be based on an average national price for the technology, and CMS is given the authority to set those prices. The mechanism has been described in regulation. It will become effective fiscal year 2003. It was meant to be this fiscal year but CMS concluded that they were not sufficiently prepared to implement it and decided to delay for a year.

DR. ROSS: But to answer your question, Glenn, the key difference between the two systems is the size of the payment bundle.

MR. HACKBARTH: So the new technology on the outpatient side is proportionately much larger relative to

the base payment, if you will.

DR. BRAUN: The beneficiary's coinsurance is paid on the APC groups and I had a question as to whether they also pay coinsurance on the pass-through codes.

DR. WORZALA: No.

DR. BRAUN: So knowing that, maybe we need to also have a column here on the burden on beneficiaries because that will vary depending on what decision we make.

MR. DEBUSK: Going back and looking from the APC code, I guess August of last year, and we come out with these C codes which were the payment codes for the devices, when they first got into that I think what happened -- and correct me if I'm wrong here -- but as they got into the C codes and trying to balance what was proper payment on an outpatient basis I think they went back and pulled out some of the devices that were already in the bundle and starting paying for them separate as well.

But here's my fear in going forward. Supposing we

take 2003, the cutoff date, and we say, all this is rolling back the device cost. We're going to assess this, look at this, roll it all back into the APC code payment comparable to the DRG type structure and then you're going to go forward. From that, as you go forward with new products, new technologies, substantially improved technologies, where a hospital really gets hurt at is some of these devices -- and let me give you an example.

Like there's a new stent out on the marketplace now that's got a zero restenosis. It's a treated stent. The price goes from something like $1,100 to $1,900 and use approximately two of them per procedure. It don't take long to do the math to see what that's going to cost.

If a hospital is in a situation where a cardiologist -- what's going to happen. You bet your life he's going to use those products on his patient. We'd certainly want it used on us. But there's a gap of time in there before CMS recognizes that. Therein lies an area

where, if we're not careful, we dig our hospital a new hole right there. And it's an expensive one.

So if we could put together a mechanism where this new technology could be recognized in a short period of time, or there could be some retroactive payments for this, but retroactive payments is something that's not been done in the past. So therein lies a major issue, can we put something together to address that need.

DR. NEWHOUSE: I think this chapter, and to some degree our discussion here, raises a much more general issue for Medicare. The issue is a device or drug, if it's a covered service, that has a high Medicare share -- that is, from the manufacturer's point of view most of the market is Medicare -- and that has a non-trivial amount of spending associated with it. An example of that would have been EPO when it first came out. It was mostly for dialysis patients, and as we just heard $250 million in spending initially.

Now the problem is, if we have a pass-through or if we have the DRG type system for that matter, whatever price the manufacturer names is reimbursed under the pass-through and ultimately rolls into the weight under the DRG system and gets reimbursed. So the manufacturer's incentive is to price very high.

Where I come out here is that there's little alternative for HCFA in this kind of case other than a fee schedule. A fee schedule also does potentially help with the lag issue, if you can get the code out fast enough and the reimbursement there fast enough because it starts to reimburse right away. It doesn't have the roll-in kind of problem that we have with the DRG. But that's I think a side issue.

I think the larger issue, and it goes beyond the pass-through system in the outpatient system, is how Medicare should deal with products that, as I say have a high -- where Medicare is most of the market and they're

used fairly widely so that there's a fair amount of spending on them.

MR. SMITH: I want to re-urge something that Bob mentioned yesterday. I found myself wishing in this chapter for some sense of magnitude. What were we talking about both in dollar terms and as a share of outpatient spending. Murray, just more generally that kind of information I think would help.

I want to follow up on something Ralph raised, in a slightly different way. Dan, the financial incentive under the phase-out option suggests that the result would be the avoidance of high-priced new technology. I think we can infer that a corollary to that would be slower diffusion of new technology, particularly in a market like the one Joe just described where we had a Medicare-intensive or Medicare-heavy market, the financial incentive was to avoid the use. I think the logical implication would be that diffusion would be slower than it otherwise would; that is

the kind of clinical implications that Ralph raised.

As I read the chapter and went back and read the material for the last meeting, which unfortunately I wasn't at, I didn't find material that helped me grapple with that question. What's the right price that we ought to pay in order to encourage diffusion? Or what's the price that we end up paying in patient care for artificially slower -- for slowing down diffusion whether artificially or not? I find it hard to think through these options without some ability to grapple with those questions, and the related ones that Ralph raised a while ago.

DR. ZABINSKI: Just one thought on diffusion. Maybe some of the physicians on the Commission can help me out. It's not clear to me that any sort of additional payment is necessary at all to get diffusion. It's the physician who makes the decision, at least as far as I can tell, on what technology to use. Whether an additional payment such as a pass-through is necessary to get the

physician to use it, or perhaps to avoid using it, I'm not sure if that really makes much of a difference.

MR. SMITH: But, Dan, if that's true, and I'd like to hear from the clinicians, but then the assertion that phasing out the pass-through would avoid the use of high cost new technology, which has some implication that clinical judgments are overridden by price judgments, that that wouldn't be true? I think both things can't not be true.

If you're right that phasing out the pass-through would cause an avoidance of the use, that's got to slow down diffusion. Now maybe that's not a bad thing in some cases where we've simply got an artificially high-priced technology. But without being able to get past the price questions I think it's very hard to answer the question of what pricing scheme is of most benefit to beneficiaries, which somehow is absent from this conversation.

DR. ROWE: My view, Dan, would be that -- and

maybe I'm Pollyanna here -- I think physicians use these new technologies when they can be helpful to their patients. You know, you see laparoscopic cholecystectomy, bam, it diffused immediately, and the use of stents, endovascular approaches to what used to be major vascular surgical procedures, very rapid dissemination throughout the marketplace.

And competition between and among physicians to learn how to use these new technologies, because in fact they've been treating a given disease all their career and here's a new, more effective approach to treating that disease. I don't think that any of them would pass a test on what a pass-through payment is.

DR. NELSON: Only if the hospital stocks it. If you're talking about an artificial joint or whatever, it's only if the hospital is stocking. They can't use it if they can't get it approved to be --

DR. ROWE: Right. But my experience, Alan, is

that -- and some of these things are very expensive, as you know -- is that what the hospitals usually do is they don't avoid stocking these things because they don't want to be a loser in the marketplace either of saying, you know, some hospital starts advertising that you can get the new thing at their hospital and you can't get it across the street.

What the hospitals do do though, on the other hand, is if there's 10 neurosurgeons, they have 11 opinions about what kind of clip they want to use. Or if there's 10 orthopods, they have 11 opinions about which kind of artificial hip they want to use. And they force them to focus on one or two options so they can have some purchasing power. I think the hospitals do do that. But they generally don't avoid purchasing the things at all. That's my experience.

MR. HACKBARTH: Does it follow from that then that option three, phasing out the pass-through, may not pose much of a risk to diffusion?

DR. ROWE: I'd be interested in Ralph's experience, whether it's the same.

MR. HACKBARTH: Certainly it's a simpler system.

MR. MULLER: My sense is, like Jack's, that by and large these judgments get made pretty instantaneously by physicians trying to do the right thing for their patients.

I think part of the reason we're discussing this issue today is there's a major mismatch between thinking you can spend 2.5 percent, which I'm sure was just arbitrarily done, and spending 13, which therefore causes, as it feeds back into the system, kind of untoward effects. My guess is we would not be having this lengthy discussion if the pass-throughs came in at 2.7 rather than 2.5. So I think part of describing this is not just the discussion of the diffusion of technology but also just, in that sense, a retrospective misestimate as to how big this would be.

To answer your question about with option three, avoiding it altogether, I think at the margin some

technologies would therefore be limited. I still think the overarching trend would be to introduce the new technologies and try to figure out somewhere down the road as to how to get paid for them. I think very few settings inside the country really limit on a real time basis introduction of a new technology.

There's some places in which it's more possible, like drug formularies, just because this is required, and other places where it's a lot less possible like devices and so forth, where there's considerable decentralization of those kinds of decisions in all settings. So I think there's variance in -- drugs a little harder to introduce because of the regulation of drugs. Other things are much easier to introduce.

But I would just like to second Joe's sense that the mismatch between two and 13 just on the surface bothers me. I'm not saying that 2.5 was right, but that's what was in the legislation. So I think moving more towards a fee

schedule is something that I would support in the sense that that might dampen some of that mismatch, especially as it rolls in a year and-a-half or so down the line into the reweighting of the APCs. So I think that would be a good option to extend.

Obviously, we put in the middle column something else that's a very high burden on CMS and we've had discussions over the fall about how many burdens we put on CMS would be a point of caution on that. It's just one more thing that they couldn't do in time.

I think going on, that's also informing this discussion, is what Chantal referred to earlier, these provisions on outpatient payment may or may not be delayed on January 1st. I think all providers are very concerned that the system is going to be fraught with a lot of complexity, not just between now and April, but for now for a long time forward. CMS has not, and understandably so, has not been able to implement this system. It's like to

have a lot of problems even when they implement.

So I think my concern about a fee schedule therefore, it would be one more burden in the outpatient system that is already overburdened in complexity.

MR. HACKBARTH: Just a clarification. My understanding of option two is that the new technology stays forever outside the APCs, and it's just unbundled, if you will, and paid on a fee schedule basis.

DR. ZABINSKI: That's right, yes.

DR. NEWHOUSE: It could roll into the APCs. The issue is really what it's going to do to the relative weight once it rolls in.

MR. HACKBARTH: That's not how I understood the option.

DR. ZABINSKI: The idea is, option one is just simply setting some sort of national rate for pass-through technology, and option two is to take all technology outside of the outpatient PPS and pay for it on a fee schedule.

MR. HACKBARTH: So under option one you could have payment on what is in essence a fee schedule on a temporary basis and then it's ultimately folded in. Under option two, what makes it distinct from option one is that it stays forever outside the APCs and is paid on a fee schedule.

DR. ZABINSKI: That's correct.

MR. HACKBARTH: It sounds like what you're arguing for is a variation on option one.

DR. NEWHOUSE: No, I'm really arguing -- there's a difficult to set rates language up there in option one and two. It is difficult to set rates but it may be an unavoidable period for the whole -- that is, there's some conditions where it just may be necessary. We in effect set a rate for EPO, and we agree on a price for EPO.

MR. HACKBARTH: We have some confusion about the basic options and further discussion without clarifying that I think is just going to confuse things. Would it be helpful to actually put the recommendations up? Do they

have language that would clarify this for us?

DR. WORZALA: You can do that if you like.

MR. HACKBARTH: But you don't think it will help.

DR. WORZALA: The two differences between one and two is that one is really just covering new technology and it's meant to maintain limited eligibility. Number two covers all technology and is meant to be permanent.

DR. REISCHAUER: How much of total payments is going to be technology?

DR. NEWHOUSE: Can't be all.

DR. REISCHAUER: That's reassuring.

DR. ZABINSKI: If you want to go to the recommendations that might be a good idea.

DR. REISCHAUER: David raised the issue that I wanted to talk about, but I was fascinated by the discussion that then took place and the considered opinion of experts in this area is that the hypothesis that has usually driven, at least politically, these pass-throughs, which is if we

don't have something like this we are denying the latest benefits to patients, doesn't seem to be shared by those who would seem to know here. If that's the case, I think we should say it. That there isn't a lot of evidence that that is.

There's a justification one can make which has to do with margins of providers, that you want to make sure that they're paid for what they're doing. But that's very different from how this has been portrayed in the political debate.

DR. NEWHOUSE: There was an example, Bob, of the cochlear implants in the late '80s when HCFA -- this was on your watch -- when HCFA basically lumped them in with a given DRG, didn't cover the cost, and 3M withdrew the product. It's come back on the market since or some version of it. There can be an effect.

DR. NELSON: We aren't in agreement, unanimously.

DR. STOWERS: That's what I was going to speak to.

Not to disagree with my learned colleagues, but in the larger urban center, the stronger hospitals, yes, I think you're right. I think regardless of what size hospital you're in the physicians try to do what's best for their patient and get the technology to them as quick as possible.

But if you get in the smaller urban hospitals or in the rural hospitals that are struggling or having more financial problems, it becomes a much closer relationship between the decisionmaking and the financial difficulty of the hospital. There can be a delaying of those technologies being brought in, and we've seen many, many examples of that, until it's financially feasible for the hospital to do that.

So I think just to make a blanket statement that across the country there's no delay in technology. I have to agree entirely here that there is a tremendous timeliness issue of getting these technologies reimbursed. So I'm really worried and that's what I wanted to speak to, is that

we just leave that blanket impression that there's absolute access.

MR. HACKBARTH: Floyd, and then we ought to turn to the two recommendations.

DR. LOOP: I don't know how practical option two is to create a fee schedule for all science and technology. I think you're asking an agency that can't get done what's supposed to be done, to do something that's a momentous undertaking, is impractical.

On option three, I thought that contained the understatement of the year: the potential disadvantage is that base rates may not adequately cover the high cost of new technology. For sure it probably wouldn't. I think then you run the risk of retarding the diffusion of good technology. I don't think we know the unintended consequences of phasing out all the pass-through payments.

MR. DEBUSK: Keep in mind with option two there, that coding system is already in place. So CMS does not

have that big a challenge there, if you choose to break it out, Joe. It is in place, the C coding system.

DR. NEWHOUSE: To be clear, I would take a subset. I think all technology is a straw man.

MR. HACKBARTH: Do you want to put up the recommendations? By the way, this is not an issue that we're going to resolve today. This will come back in January.

DR. ZABINSKI: Under option one, the recommendation we would offer would be, the Congress should replace hospital-specific payments for all pass-through devices with national payment rates that reflect hospitals' acquisition costs. The Congress also should replace payments for pass-through drugs and biologicals based on average wholesale price with national payment rates that reflect hospitals' acquisition costs.

Should I go on to the next option?

For the second option, that's a fee schedule for

all technology. We have, all drugs, biologicals, and medical devices, both pass-through and non-pass-through, should be removed from the outpatient PPS and paid under a fee schedule that reflects hospitals' acquisition costs.

And the third option, the phase-out, would be, pass-through payments should be phased out so that all technologies are paid through base payment rates in the outpatient PPS.

MR. HACKBARTH: A question about number one. In our comment letter on the regulation, one of the problems we identified was that the mechanism created incentives to jack up charges. So that's one issue that we address in option one. But other problems were also identified. I'm not sure that we're addressing all the points that raised in that letter. Frankly I'm blanking right now on all the issues that we did bring up, but I know this wasn't the only point.

So if we're going to have a modified pass-through, I'm raising the question of whether there are other problems

that need to be addressed in the pass-through approach.

DR. ZABINSKI: I'm not completely recalling effectively either, even though I wrote the letter, but I think a lot of it was due to -- we pointed out that, first of all they set this 2.5 percent cap. But then Congress turned around and allowed all sorts of additional --

MR. HACKBARTH: Right.

DR. ZABINSKI: But I think that a lot of people liken this to a snake swallowing rat and the rat has to pass its way through the snake. The idea is that you have a lot of these pass-through items right now and that caused an exceedingly large disparity between the 2.5 percent limit and the actual payments.

But the idea is that in the future it's really expected -- Chantal talked to somebody that represents the device industry and I also think somebody from CMS and they both said that they really expect a very small number, at least a relatively small number of pass-through items into

the future. So I think this 2.5 percent limit, even if it's exceeded, it won't be exceeded by a very wide margin. Chantal can correct me on that.

MR. HACKBARTH: You find that credible? I've heard people make that point, that this was a temporary problem.

DR. WORZALA: Yes, that seems to be consensus.

MR. MULLER: Why do we choose so broadly, to go back to Joe's point. We have in the pass-through a limited set of devices that, as Dan said, got expanded a bit. But why expand 100 percent. We want to keep this for new, important technology rather than --

DR. ZABINSKI: It wouldn't be additional payments for the old technology. It would just be setting a rate that's appropriate for the old technology. There wouldn't be any sort of pass-through payment for it.

MR. MULLER: No, but I'm saying is that when you say all drug, biologicals, and medical devices, most of

those are supposedly carried inside the APC system, so why do you want to take them back out?

DR. WORZALA: That rationale would just be to limit the disparity in how payments are made for complements, things that you could choose between one versus the other, and one is paid one way and one is paid another way. The notion is that you get rid of that disparity which tends to give an incentive to provide services using pass-through items as opposed to items bundled.

MR. MULLER: But my suggestion is, and it's in some way -- the way two is now stated I don't like it as much as I did before when I said that. Hadn't read it then.

The question we have is how to get the appropriate diffusion of new technology without having excessive cost be allowed in that system that skews the overall outpatient payment system in a way that gets APCs reweighted in inappropriate ways, and transfers going on. So to me, trying to have both an incentive for the diffusion of

technology without excessive margins to be made and skewing to go on is what we're trying to figure out here.

So that strikes me that somewhere between one or two that allows, as Joe has indicated, some fee schedule for a limited number of these new technologies -- not 100 percent, and not 100 percent of devices, drugs, and so forth, and to remove the incentive -- to remove whatever -- you know, if the reason we went from 2.5 to 13 is that the list got too big as opposed to the price got too high -- and I'd like to hear your judgment on that -- that's a different matter.

MR. HACKBARTH: It really sounds to me, Ralph, like you are arguing for option one.

DR. NEWHOUSE: Some combination of one and two.

MR. MULLER: Yes, some combination of one and two.

MR. HACKBARTH: Basically two says that we pay on a fee schedule, and option one also includes that we pay on something like a fee schedule.

DR. ROWE: No, it's acquisition cost. So if you spend $40,000 for a stent; fine, the hospital pays and we pay $40,000. That's not a fee schedule. The fee schedule is being determined by the manufacturer in that case.

MR. HACKBARTH: Although if you move away from hospital-specific cost-to-charge ratios and go to nationals you can dampen that incentive and you have a fee schedule --

DR. NEWHOUSE: Why? It's still there. Everybody faces the same cost from the manufacturer.

DR. ROWE: Yes, it's a single source producer and he's going to charge everybody the same rate. What we'd like to say is what Medicare is going to purchaser -- it's a large purchaser and they're going to pay --

DR. NEWHOUSE: It's not the hospital's charge. It's the manufacturer's.

MR. HACKBARTH: So let me just continue trying to get clarification. So what you're saying is in option 1A that involves a pass-through for a separate payment for new

technology, and let's not go back to the all the old stuff and put it on a fee schedule. But when we have the new stuff that it's a fee schedule as opposed the current mechanism.

DR. NEWHOUSE: If it's a big Medicare share and if it's enough cost, that's how I would segregate. I agree with Floyd that we can't take on everything.

MS. RAPHAEL: I just have one point of clarification. I feel in this realm do-ability is very important. We have to decide what to cover, how much to pay, and you want to do it with some rapidity so that you can get this into the hands of whoever is practicing patient care. I'm not entire clear on the fee schedule proposal, whether it's doable and I'd like to better understand that.

Because if this is, even if we think of it as an interim solution on the way to getting better data and being able to put it into the base rates, an interim solution should be something you could do fairly soon. I just would

like from those of you who are more familiar with this, to get a sense of whether or not this is in fact doable.

DR. NEWHOUSE: My problem isn't an interim problem, it's an ongoing problem.

MS. RAPHAEL: So you would never fold it into the base rates.

DR. NEWHOUSE: The issue is what price goes into the base rate and who determines it. As Jack said, in the particular case of products I'm concerned about you essentially have the manufacturer determining the base rate.

MS. RAPHAEL: But you can do that differently. I thought you could use the fee schedule on the road to having more accurate data for the base rate.

MR. MULLER: I agree with your argument, if a fee schedule takes 24 months to develop and until you develop it you can't do any of this access to technology then that would be, to me, kind of don't do it that way. Because the point is to get the diffusion of technology. I concede if

it takes CMS in the scale of all the multiple things they have to do, so much time to get the fee schedule, that would be an argument against using the fee schedule.

MR. HACKBARTH: We're not going to resolve this today but I think we've identified a clear question that would be helpful to have some more thinking about. It's not a clear question to you, Dan, so why don't you --

DR. ZABINSKI: Yes, I'm a little -- to me, option one, I still get the idea that what Ralph is talking about is a somewhat focused special payment for what, new technology?

MR. MULLER: Selected new technology, in a real outlier context.

MR. HACKBARTH: So it's higher than some percentage of -- I'm not sure what. But it's expensive new technology that you're worried about.

DR. ROSS: So if you set a high enough price for it you move yourself into the pass-through category?

I think part of what I hear from commissioners is almost a belief system which is that if you believe that everything is guided by clinical decisions I think that actually drives you to option three; sort of, declare victory, quit worrying about it. If you think financial incentives are extremely important then you go to one or two, and that starts to get mostly to operational questions at that stage.

MR. MULLER: I think I would agree with Ray's point. I'm not saying that financial decisions never make any difference. Obviously, when one starts putting in prosthesis that cost $20,000 and five stents at $2,000 a pop and the procedure gets reimbursed $1,100 you start saying, just the stents themselves are $10,000. So people do make those kind of judgments. I don't want to deny that. But I think, on the other hand, in that kind of example if something costs $1,500 versus $1,100 -- everybody picks their spots as to where you make -- where you try to

intervene.

I'm just saying, one does not want to really dampen -- and the examples that Jack gave are overall savings to the system. When you look at the whole system there, having people with laparoscopic surgery and not being admitted and so forth are overall savings. So in that sense you want the stuff out there to save overall. You can't just look at it in that kind of narrow way.

So my point is just to Dan, a more limited set that has some kind of threshold task -- not all. And if it's feasible, I fully concede to Carol's comment; if it takes forever to get the fee schedule going then that's kind of an argument against the fee schedule.

MR. SMITH: Ralph, let me make sure I understand. What you'd argue for at the moment is option one modified by some threshold, some price or price increment threshold, and changing from acquisition cost to a fee schedule.

MR. PETTENGILL: It's really important to remember

that we got here because we don't know. We have a pass-through that was enacted because CMS doesn't get the data to include it in the APC relative weights. If they had the data, then this whole problem would be moot. So the question really is, how can you construct something that will work in the interim when you don't have the data to begin with? That's the question.

DR. NEWHOUSE: I think, to reiterate what Murray said, I think the ultimate -- I don't think the issue is a transition problem. I think the ultimate issue where I would come down, if the clinicians are right than option three is clearly better. And if financial considerations are important then I would have said, as Ralph did, some combination of one and two where you go to two in those cases where it's a high Medicare share and there's a non-trivial amount of spending. So there's some trigger that puts you into a fee schedule as in the erythropoietin example.

MR. SMITH: Just one comment. From this side of table -- and Carol unfortunately isn't here -- but we thought we heard the clinicians speak with more than one voice. At least part of what I heard was a big city voice and a not-so-big city voice.

DR. WORZALA: Can I just make one -- I'm sorry to do this, Glenn. I never answered Ralph's question about whether it was price or volume that took the 2.5 percent to 13 percent. The answer is both, but volume played a bigger role. Going forward, as we stated before, volume should play less of a role. We focused on price because we thought that the volume issue and the eligibility criteria were moving in the right direction, becoming more selective, and that the key remaining problem was how the price was set.

Apparently we didn't give you enough background on that sort of thing, so for January I'll give a much better description of the eligibility and how things are moving in that realm.

DR. NEWHOUSE: Chantal, with all respect, I don't think Ralph's question can be answered because the price that is set is not independent of the reimbursement methods. Therefore one would have to ask, what would the price have been under some alternative that wasn't this system, and I don't see how we could have known that.

MR. HACKBARTH: We need to move on. The next subject on the agenda is adjusting for local differences in resident training costs.

MR. LISK: This is the last presentation for the day. Briefly I'm going to go over -- briefly review. This is a congressionally required study. I'll briefly review the mandate, review the Commission's past views on GME, review the GME payment method, look at what the alternative adjusters are, and the policy considerations you would need in making selection of adjusters, and the potential actions or recommendations you may want to make.

So the congressional mandate, Congress in

committee report language asked the following question. Is the physician geographic adjustment factor an appropriate factor to adjust direct GME payments for geographic differences in the cost of physician training? They wanted the Commission to make recommendations by March 2002 on a more sophisticated or refined index to direct GME payment amounts if we found a more refined index to be appropriate for this purpose. I want to emphasize for the Commission here is the if appropriate on here. So we don't necessarily absolutely need to make recommendation if we find the GAF to be appropriate for this purpose.

To briefly review the Commission's views, the Commission has previously stated in its reports on GME, et cetera, that trainees bear the cost of general training by accepting lower wages and paying tuition, and the Medicare education payment should be treated as patient care costs. Now if MedPAC's recommendation were implemented this whole issue would be moot because these payments would be folded

into the payment rates, which in that case might imply that the area wage index would be used for adjusting these rates in part.

So let me briefly now review Medicare's payments for physician training. Payments are a product of three factors: hospital-specific per-resident payment amounts, a weighted count of residents, and Medicare's share of patient days. Those are basically the three main components.

The hospital-specific amounts are based on 1984 costs updated for inflation. The BBRA, the Balanced Budget Refinement Act established a floor and rate of increase ceiling for these payment amounts based on a locality-adjusted national rate. The ceiling was set at 140 percent of the locality-adjusted amount. BIPA raised the floor payment rate to 85 percent of the locality-adjusted national-adjusted amount.

The Congress chose to use the 1999 physician GAF for this locality adjustment. I want to point out though is

that in the original House version of the bill -- this is what came out of the conference committee -- the original bill passed by the House was somewhat different. They established actually a national rate with a geographic adjustment, so there would have been no variation. Right now there's a corridor of variation that's allowed, but under the House bill there would have been no variation except for the geographic adjustment. They used the hospital wage index for that geographic adjustment.

So how much variation is there in residency salaries and training costs? What I have up here is showing the variation in first-year stipends based on data from AAMC. Now that data is from 2000-2001, and the payment and cost information is from 1998. So the years aren't quite comparable, but the amount of variation shows at the 10th and 90th percentiles that there's not a lot of variation if we look at a subcomponent of residents' cost in terms of residents' stipends. So it's not a huge amount of variation

compared to the variation in per-resident payment amounts before we make these adjustments.

So what are the alternative geographic adjusters that could be used? There's the physician geographic adjustment factor which is the factor that's up there, and the hospital wage index are the two off-the-shelf adjusters that probably could be used, which the Congress considered. There are three main differences between the physician GAF that I think are important to point out, both between the physician GAF and the hospital wage index in both their structure, the number of components of cost that they're measuring, and the weighting scheme that's used, the amount of variation that the indices also reflect, and the geographic areas used for these adjustments.

To get a little more specific so you understand the physician GAF a little bit more, it's a multicomponent fixed weight index. So there's three main components, physician work, practice expense, and malpractice insurance.

But in that index it's also important to point out that the physician work component, which makes up about half of it, only 25 percent of the variation in that component is reflected. That's actually by law only 25 percent of the variation is reflected. So it's not reflecting the full variation in those inputs. And they're not measuring actually physician costs. They're using other proxies to measure components of physician salary costs in that component.

The other major factor then is also the area, the geographic area that it's based on. The physician GAF is based on carrier localities, which there are 89 of across the country, and 34 of those are statewide. So it's not as narrow in terms of the areas covered as the MSAs would be with the area wage index.

DR. NELSON: What is the 50th percentile, do you happen to know, in terms of costs? You've got 10th and 90th.

MR. LISK: The 50th percentile, or the average is currently at $98,000 in terms of cost.

DR. NELSON: The 50th percentile is $98,000.

MR. LISK: It's the average. It's not the 50th percentile. It's what the average is. I can't remember what the 50th percentile is.

Then on the hospital wage index only measures one component of cost and that's average hourly wages within an MSA. That's reflecting variation in input mix in terms of the mix of employees hospitals use. That index is applied only to 71 percent of the base cost for hospitals. In our analysis that's what we have -- and the numbers that I'll be presenting, that's what we're assuming is that the index is applying to 71 percent. That's something that could be discussed if you thought the hospital wage index were a more appropriate index.

So the wage index does reflect variation in labor mix across areas. It is based on 327 MSAs and 48 statewide

rural areas.

When we get to these other two indexes that could be potentially used is a residential and teaching physician wage index. Such an index could be developed from the wage index data that's used on the hospital cost reports. So an index would narrowly focus on one component input cost to residency training.

However, there is some issue of quality of that data. There's a potential concern, and I think one of the main issues is a wage index is based on average hourly wages, and what do hours mean for residency training, for instance? I think there's probably a large variation in that versus what variation you would see in actual stipends as shown by the AAMC data. That's one of the problems with potentially developing that data for that use. So if something else was developed you'd need to probably collect some other data than what's off the hospital wage survey.

Another option would be resident payments and

costs directly from the cost reports and using that. Such an index for that would reflect variation in input mix across areas. Of course, Congress did not select that. They could have developed an index like that, and it appears they probably did not want to reflect that type of input mix variation across areas, although that's always still a possibility for you to decide on.

Then the final option is really a composite index that could be developed with some combination of the above indices.

The next table shows some of the index levels under some of the options: the physician GAF; the hospital wage index, assuming again it's applied to 71 percent of the payment rate; a resident payment index. So that gives you an idea what the variation is across these selected geographic areas for resident payments and first-year stipends for where we have data from AAMC.

MS. BURKE: Just a quick question. There's nobody

in the west --

MR. LISK: Yes, I can give you some idea about the west. Interestingly, salary rates on first-year stipends, for instance -- we didn't have it for 2001 from the AAMC data I had, but in previous information from previous years of cost report surveys they did California, for instance, had lower salary costs, stipend costs for residents in Los Angeles and San Francisco. They were below average in fact, which is fairly surprising given -- their costs have historically been lower than other parts of the country, too.

DR. STOWERS: Craig, about 50 percent of GME is in markets smaller than this. You know, the Tulsas, the Denvers, the non-big academic medical centers. It would be interesting to see what the impact on these are in that. Because this includes only about 50 percent of the GME size.

MR. LISK: Right. Part of this is what I had information on with AAMC data which only reports on where

they can get data from more than five providers in a particular market. So they don't include those submarkets. You see, in terms of the stipends, you still don't see the large variation in stipends. And there are some inconsistencies about how these different indices look across the markets.

Although if you look at the difference between the physician GAF and the hospital wage index and doing a cursory look at from mid-sized to large markets -- not the really small markets -- the greatest difference you see is between -- is in San Francisco where the hospital wage index is 11 points higher than the physician GAF, for instance. If that gives you any kind of indication of that type of stuff.

But there's some wide variation where in some markets, just because of the few hospitals they have, some of those markets have very high per-resident costs for some reason, potentially because of how that hospital allocated

those costs. So on that level you'll see greater variation.

Dallas is an example where you see a low per-resident payment amount compared to those other costs. What reason there is for that I'm not certain.

MS. BURKE: What's the current distribution, geographic distribution of residents?

MR. LISK: It's still loaded very much in the east. I can't remember exactly. I think New York trains about close to 20 percent, I believe, of the residents. And there's a lot in Pennsylvania, for instance, and New Jersey, Boston as well. But then you have other markets, Chicago. Los Angeles is pretty big, and certain of those. But those are the big areas.

DR. WAKEFIELD: Craig, will we have the data that Ray was speaking to to inform this piece for the March report, or were you just saying there just aren't data on residents in those smaller --

MR. LISK: No, there is not data on the first-year

stipends from AAMC on those smaller markets. But when I showed you then the 10th to 90th percentile you saw what variation in stipends there is: 0.91 to 1.09. There's not a huge variation there. It's a relatively small variation in what's there.

So you need to keep that in mind in terms of the overall picture here of what's appropriate for what you want to do. I think my next slide I want to talk some about what the implications for changing the policy would be.

DR. ROWE: Let me just understand. The actual payment now, the corridor is 0.85 to 1.4; is that right?

MR. LISK: It's 1.4, but the 1.4 is the rate of increase ceiling. So think of those hospitals above that rate increase ceiling are having their payments reduced as much as 12 percent from what they are. So it actually goes way above that. So if someone is 180 percent of the national average, they'll go down to 168 basically, after the full phase-in. So they'll still remain well above the

national average given the current policy.

MR. MULLER: But they get reduced by not going up.

MR. LISK: Correct. But the total impact I'd say is about, would potentially be about a 12 percent reduction.

MR. HACKBARTH: Craig, do you want to just go quickly through the remainder of the presentation?

MR. LISK: Yes, that's what I'd like to do, because I think if we look at the implications for the policy changes, one is the floor payments for many hospitals would change, which would affect their payment amounts. Generally, given the alternatives, it would lower a lot of the payment amounts because there's less variation in physician GAF compared to the hospital wage index, although there will be some variation going in both directions.

Different hospitals will be affected by the rate of increase ceiling, which would create some complications on what you do about when one hospital had their payments frozen under one index but wouldn't under the other, and

then vice versa, what you would do in that situation in a policy context. We may also change total spending.

So you need to consider also the work involved in changing the index from what's currently used, and whether it's worth the work involved for HCFA or someone else, and whether any alternative index would actually be better, given its current use. Now I think there may be a different opinion if you went to a national payment rate, but I think that's one of the considerations that needs to be made here is whether use of -- given the current use, whether the physician GAF is appropriate.

So in terms of policy considerations -- I'll not say questions here -- policy considerations, you need to consider how well do the alternative indexes track variations in costs, what did the Congress want to achieve with this policy? One was payment relief. Two was narrowing the variation. There's some implications that they wanted -- from some on committee that they were trying

to put in a policy the intent of the Commission's recommendation of folding GME payments in without necessarily eliminating the payment by establishing what would have been a national rate.

What type of variation would you want to reflect? Is it input prices or input prices and the mix of inputs used, and does it need to be specific to residency training or not.

And what level geographic aggregation is appropriate? That issue is appropriate if you are developing an alternative index and the number of providers you have to determine what that index level is. Which in many cases, for the wage index, for instance, areas, the MSAs, two-thirds of the teaching hospitals are in markets with three or fewer teaching hospitals, for instance. But there's also the issue of the homogeneity of the markets for resident wages, too, that should also be considered.

So leaving that, the final slide, are the

recommendation options, or really what you can do is, one, you can find that the physician GAF is appropriate for this purpose. You could reiterate your recommendation that direct GME payments be folded into patient care payment rates. You could recommend the use of the hospital wage index, or recommend the development of a wage index based on resident and teaching physician wage data. I'll leave it at that for your discussion and answer any other questions.

DR. NEWHOUSE: I've got to run out so I want to say why I want still another option on the table. The variation in cost reflects mostly what went on in 1984, cost allocations and then how one treats teaching faculty. The spirit of this request to me is, should we adjust for differences in factor prices, which is not the 1984 cost allocations. It's how much I have to pay to get my residents and/or faculty.

What you showed is there's very little variation in that across the country. I'd suggest if we want to

adjust for it at all we actually use the historic stipend relatives to adjust. So New York would get 16 percent more than the national average, and so on. Or else we just say the game isn't worth the candle and not worry about it.

But I think the hospital wage index, all of the indices you have down here seems to me to just introduce more noise in the system. It doesn't really correspond to adjusting for what hospitals have to pay to get residents to come to their hospital because they are in a high cost or a low cost of living area.

MS. NEWPORT: I guess my question is more on a process line. Our previous recommendation was -- what in your recommended options -- and I know they're just for discussion -- is it contrary to our previous recommendations, or are we amplifying our previous recommendations? I was struck by your comment in the summary which is basically this issue would be moot if they had but adopted our other recommendations. How do we

achieve consistency, or do we need to achieve consistency?

MR. LISK: That's a good question and actually I think the answer to it is, Congress was fully aware when they implemented this policy what the Commission's recommendations were. So you could interpret this as a very specific request to what is the current policy compared to what the Commission previously recommended. Or if you really want to keep reestablishing the Commission's previous positions that would be, you did this, but that's not what we wanted type of thing. So I think those are kind of the two --

MR. HACKBARTH: The other alternative is in the preamble, if you will, say this is what we've recommended in the past but your request reflects that you don't agree with that, so we've been asked a different response, and our response to the question is.

MS. NEWPORT: I think there's value in perhaps reiterating this. I just want to make sure that we're --

okay, you didn't like that so we'll try something else. I think if there's value in what we did before we should --

MR. HACKBARTH: I would not feel comfortable just saying, we stand by our previous recommendation. We will not answer your question. That's not appropriate.

MS. NEWPORT: No, I'm not suggesting that. I wanted to bring that discussion out so that we understand what path we're trying to drive between the two bounds, now that I have a renewed interest in GME.

MR. MULLER: It strikes me we were being asked a narrow question on the index, and obviously all these other discussions like everything else we discuss have to be taken in context. But it strikes me that we're being asked an index question here. We can, as you say, say there's a big, broad discussion to go on here. But my recommendation would be that we focus on the index question rather than on the broader at this time, because I think the broader issue radiates a lot of our discussions.

DR. ROWE: My sense, recalling the origin of these discussions when I was spending my time differently than I am now, is that the major interest was really in reducing the variation, which was really quite egregious. There were front page articles in the New York Times about the differences between Houston and New York, et cetera. And that the changes that have been put in seem to reduce the variation rather substantially from what it was before with the lowest ones now getting 85 percent of the national, and the highest ones progressively getting ratcheted down.

So I guess my sense would be that after saying that -- after reminding them of our previous recommendation, might sense would be that the system that's in place now is satisfactory. It is not worth the candle of trying to rejigger it again. That's where I am.

MR. HACKBARTH: I would feel comfortable with that also.

MR. LISK: I guess the issue is, do you want to

make consensus on that, so the issue of whether we bring this back at the next meeting or not?

MR. HACKBARTH: No, we need to bring it back. We've lost a number of commissioners, so we have to have one more discussion.

Okay, time for the public comment period, which will last 15 minutes.

MS. CLARK: Hello, my name is Shelly Clark and I'm representing National Renal Administrators Association today. I'm their president. I'm from Roanoke, Virginia and manage several rural and metropolitan dialysis facilities. I worked for 10 years in a hospital-based system and closed three of those dialysis units. I worked for 10 years in physician-owned clinics and helped them open some rural health care centers, and I have closed or help closed to two of those, and now manage some of these same dialysis facilities for a chain after we were acquired.

So I'd like to make just a few points on Ms. Ray's

presentation. It's interesting to me that whether or not I have to close any more dialysis facilities may rest with you.

I'm not an economist. I'm an R.N. However, I can deliver a clear message from all providers. As Ms. Ray has already identified, the composite rate is not covering our cost of care. The reimbursement is fixed except for congressional changes in '91, '99, and 2000. We've had a history of fold-ins with meds and labs, unfunded regulatory mandates, technology advancements where we don't get any increases, improved quality of care, and soaring staffing costs with no annual updates.

As a note of correction to her presentation I'd like to note, facilities themselves cannot bill for lab. Only labs can bill Medicare for the labs. So the 4 percent factor that she mentioned may need to be revisited by MedPAC.

Everyone analyzes teh cost reports, as I do, and

Ms. Ray noted that they do not include medical director and administrative salaries. We prepared a handout for you that on page 9 will clarify some of those percentages I think you asked about. Cost reports also do not include bad debt for non-composite rate ancillaries, or the effect of Amgen's two-year price increase for EPO, which you're aware of.

It is very important that I make these notes on separably billable drugs and margins. Oral drugs are very costly to the beneficiary. When we write our patients these prescriptions, they cannot afford to get them filled. IV meds are where we can steer the patient's quality of care.

There was an instance a few years back where the IV iron manufacturer had to recall the drug. We have evidence that we went back to oral medications, our quality went down the tubes for our anemia management for our ESRD patients. We'd welcome the opportunity to get some of this statistically important information back to you to look at before you make any recommendations.

It would be also very premature to make any recommendations about including the new form of EPO in a bundle or in the composite rate in that we've not even seen that in the market yet. Until it's there, working, and we can analyze it statistically, it's too premature to include.

So in summary, dialysis providers have been unjustly compensated as compared to other health care providers. I found it very interesting on the discussion of rural hospitals and some of the hold harmless and other factors that they have to protect them. All the dialysis facilities have had is an exception request processed that I have some personal experience with. It's difficult, it doesn't work well, and it's now been taken away from us. So unless that's restored we're still in trouble, as you can see from the lack of the data points she had on the one slide with our decreasing margins.

Please review our recommendations we'd like to have you consider. We want you to look at the true

definition of what's in the existing composite rate and do a price recommendation based on the frequency and cost of what we really do. It's critical we get this in 2003. We must have annual update mechanisms calculated in. I'm not an economist and it's very complex how you do that, but it's critical to us.

Going forward, then we can explore what the CMS is going to report this coming year. We would like to work with the industry on perhaps looking at an expanded bundle to protect us from more crisis in the industry that we're looking at now.

Thank you.

MR. LEWIN: Hello, I'm Howard Lewin and I represent the Renal Leadership Council. First, a piece of information. Some data from three large chains is that currently 77 percent of the patients within the large chains are Medicare primary covered, and 23 percent have commercial insurance. Some of the patients with commercial insurance

are Medicare eligible, but since commercial insurance does typically pay dramatically more than Medicare there is no secondary payment there.

What I'd like to do now is address the point about is the current payment reasonable. There was some data presented earlier today that in 1999 the combined payment was 7 percent above cost except for medical director fees and unreimbursed bad debt on non-composite services.

Medical director fees have risen dramatically over the past 10 years, primarily because the number of nephrologists in practices remain very constant, and the number of dialysis centers has risen dramatically. So increasingly, nephrologists have a lot of choice about where they would provide medical director services. At this point the $250 an hour number is very close to the typical medical director reimbursement within the large chains.

One example of unreimbursed bad debt is in the area of Epogen. Currently, large chain providers do pay

about $8 per thousand units for Epogen, and the Medicare payable is also $8 per thousand for Epogen. That $8 cost for the providers does not include any G&A cost associated with drug delivery and other related costs.

The reasons that the chains look financially healthy today is that -- and this is data for two large chains -- is that the ratio of non-Medicare and Medicaid reimbursement to Medicare-Medicaid currently is 1.83. That dramatic difference in the reimbursement rates for non-Medicare payers compared to Medicare drives the industry's profits today.

The implications of this large gap are, first, that new centers are increasingly opening where there are many more non-Medicare patients than the national average. Again, this is data for three chains. The non-Medicare percentage in the 71 new facilities opened in 1999, 2000, and 2001 -- I have two years of data -- is 31 percent non-Medicare in 2000 and 36 percent non-Medicare in 2001. This

is, again, compared to 23 percent non-Medicare overall.

Additionally, for facilities closed within the same three chains for 1999, 2000, and 2001 -- and this is in the case of the 40 facilities closed -- the percentage of patients that had Medicare primary is 84 percent. Medicare patients are increasingly in danger of losing access. Traveling long distances three times a week for treatments that increasingly are at a very inconvenient time, either very, very early in the morning or very, very late at night, in areas where there are the vast majority of Medicare patients compared to the national average is increasingly what's happening based on the current payment system that we have in place.

Thanks.

MS. CUERVO: Good afternoon. My name is Acela Cuervo and I am the general counsel for the American Association for Home Care. We represent home health agencies and suppliers of home medical equipment. There is

a payment issue that pertains to home oxygen services that I would like to make you aware of. It truly is not unlike the issue of the ESRD update.

The BBA reduced payment for home oxygen services by 30 percent, and then froze the update through 2002 and all subsequent years. This means that Medicare payment for home oxygen services are indefinitely frozen at 70 percent of the level that they were at in 1997. The BBRA did authorize small payment updates for home oxygen for 2001 and 2002, but these updates are temporary. So at the end of 2002 the payment levels for home oxygen will revert back to what they were, 70 percent of what they were in 1997.

This has tremendous implications for Medicare home oxygen patients, which as many of you might know, tend to be the sicker and more elderly frail of the Medicare beneficiaries. As costs for delivering quality home oxygen services rise over time but the Medicare reimbursement remains flat it becomes increasingly difficult for our

members, who are -- the vast majority of suppliers tend to be small, independent companies -- to provide the level and quality of care that the Medicare beneficiaries need.

We believe that it's very important that Congress restore the home oxygen services benefit to make it eligible for a CPI update beginning in 2003 and all subsequent years. We would welcome the opportunity to work with you and provide you with further information on this issue.

Thank you very much.

MR. GRAEFE: Thank you, Glenn. Fred Graefe of Baker & Hostetler on behalf of Invacare, the largest manufacturer of home medical equipment. It's headquartered in Cleveland. I'm here to support the application of Acela and her trade association. Invacare is a member of that trade association, and it is critical for Invacare's customers, which is, as I said, the largest manufacturer of home medical equipment including oxygen systems.

The final point, that Invacare is not only the

largest manufacturer in this country, but it's also the largest creditor for its industry. With the recession and post 9-11 and all those bank credit crunch, it's exceedingly important that, we believe, that the Commission look at this issue so that you can report to Congress next year in a timely fashion when this issue will certainly come up.

We look forward to working with the commissioners and your staff. Thank you very much.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges. Just a quick point on the outpatient arena. It seemed you were circling around a little bit the issue of a potential fee schedule by being above a threshold amount. It seems very akin to almost modifying the current outlier provision on the outpatient side. You still include hospital-specific costs with the outlier, but there is an option there of looking at the outlier as a potential option for dealing with the pass-through issue.

Now, of course, the current outlier pot would not be enough money to deal with this issue. But I think that's another option you might want to think about as you move forward.

Thank you.

MS. MENSCH: I'm Stephanie Mensch from the Advanced Medical Technology Association. We represent device manufacturers. I just wanted to reiterate a couple of points, indeed that one of your staff members made. That is, the dearth of good data in the outpatient setting to help construct exactly what the policy should be on some of these things. That was one of the reasons that AdvaMed supported the concept of a pass-through program in the beginning, because CMS when it constructed the original APC rates did not recognize device costs in it. They're still have problems with it. The reason you saw 2.5 percent to 13 percent in the fold-in this year is because the base rates just haven't reflected the cost of devices and technology.

We believe that with continuing the pass-through payment program after 2003 will allow for new technology in all hospitals that require it.

One other thing I just wanted to clear up real quickly, the pass-through program is not a pass-through directly to the device manufacturer. It's a way to assist hospitals to get paid for the devices. It goes to the hospitals. It doesn't go to the manufacturers.

The other point is that marking up devices is not as easy as it may sound on the surface. The hospitals are constrained by the charges that they give to all of their payers, and each year CMS goes back and looks at what their charges and will adjust their cost-to-charge ratio. So it does have future impact.

Anecdotally, we believe that some of the higher cost devices are not marked up as high as other items that the hospital may mark up. So it's a very complex thing.

Finally, as you know, we do not support separating

out and developing a fee schedule for devices under the APCs. We believe they should be put into the bundle, the bundled package of the APCs, and that there should be a transition year to allow collection of data -- not only price data, but the utilization and matching the APCs.

Thank you.

MR. HACKBARTH: Thank you all very much. We're adjourned until January.

[Whereupon, at 12:46 p.m., the meeting was adjourned.]